PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 08/16/2013	
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	IC, THE	ı	STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	D 4.T.E.	ON
{W 000}	INITIAL COMMENTS		{W 0	00}			
{W 102}	survey to the PCR survey the 23 day revisit survey the full annual recertification of the full annual received the full annual	2, 8/13, 8/14, 8/15 and 768 6G245 34520 Conso reflect state findings in IAC 9. leted 8/23/13 by Ruth	{W 1	02}			
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING			8/16/2013	
	ROVIDER OR SUPPLIER	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{W 102}	body failed to ensure in regard to the client #3 was not ne client's weight loss. ensure the facility's health care needs of failed to ensure the of all allegations of conducted thorough implemented correct recurrence of neglectients. Findings include: 1. The governing be Condition of Particip of 2 sampled clients client (#3). The gov implement its written prevent neglect in rehealth/medical need to conduct a thorough an allegation of negmedication error, and were followed. Please 2. The governing be Condition of Particip for 1 of 2 sampled colient (#3). The gov the facility's Health of care needs of the cligoverning body failed Health Care Service and/or addressed a	e client #2 was not neglected nt's diabetes and to ensure glected in regard to the The governing body failed to nursing services met the f clients. The governing body facility initiated investigations neglect when informed, investigations and/or tive measures to prevent et in regard to discharged ody failed to meet the pation: Client Protections for 1 (#2) and for 1 additional terning body failed to a policy and procedures to egard to the clients' les. The governing body failed gh investigation in regard to lect in regard to a nursing and to ensure corrective actions are see W122. ody failed to meet the pation: Health Care Services lients (#2) and for 1 additional terning body failed to ensure Care Services met the health	{W 10	2}			

	AND PLAN OF COPPECTION INDESTRUCTION NUMBER		` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		15G245	B. WING _			08/	16/2013	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
A DC OF N	ODTUMEST INDIANA IN	C THE		4378 FOURTEENTH LN				
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{W 102}	clarification in regard physician, to ensure a and/or developed for body failed to ensure Services monitored a weight loss. Please s	ugar levels, and to obtain to when to contact the a risk plan was revised client #2. The governing its facility's Health Care and/or assessed client #3's see W318.	{W 10	02}				
	written policy and pro of client #2's diabetes to ensure the interdisc and/or addressed the sugar levels in regard governing body failed specifically indicated monitored at night in signs/symptoms of lowersure any change of immediately addresse failed to monitor clien sugar readings as out physician's order and governing body failed nursing services met regard to assessing the discharge from the hoservices carried out particles the client's phand/or notified the phylevel readings. The gensure the facility information in the interdisciplinary facility to review/addresugar levels in regard develop a risk plan for governing body failed governing body failed	how client #2 would be regard to the client's w/high blood sugar levels to condition could be ed. The governing body t #2's low and high blood clined by the client's for program plan. The to ensure the facility's the client's health needs in						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4378 FOURTEENTH LN HOBART, IN 46342	I	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	DATE
{W 102}	(medication error) at facility's governing be written policy and proof client #3 in regard The governing body initiated an investigat of possible neglect rewhen the incident occonduct a thorough in allegation/incident for the governing body implemented recommensure all group hom regard to hospital dis The governing body implemented recommensure all group hom regard to hospital dis The governing body implemented recommensure all group hom regard to hospital dis The governing body implemented recommensure all group hom regard to hospital dis The governing body implemented recommensure all group hom regard to hospital dis The governing body implemented recommensure all group hom regard to hospital dis The governing body implemented recommensure all group hom regard to hospital display implemented a client's signs/symptolevels to ensure its Homonitored client #2's readings as outlined order and/or program timely upon discharge ensure nursing service orders as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, to was notified of a hospital physician of high blowers as written, and the physician of high blowers as written, and the physician of high blowers as written, and the physicia	d to an allegation of neglect the time of the incident. The ody failed to implement its ocedures to prevent neglect to the client's weight loss. failed to ensure the facility tion in regard to an allegation egarding a medication error, curred and/or failed to investigation into the riclient #2. failed to ensure the facility nended corrective action to be nurses were retrained in scharges. failed to ensure its Health incally indicated how client #2 at night in regard to the ms of low/high blood sugar change of condition could be ed. The governing body ealth Care Services low and high blood sugar by the client's physician's in plan, assessed a client efrom the hospital and to coes carried out physician's ensure the client's physician pitalization and/or notified the od sugar level readings, to was informed/involved in the in process to assist the facility eclient's elevated sugar eclient's diet, and to develop	{W 1	02}		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING				≺ 16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	IC, THE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN HOBART, IN 46342		10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 102}	obtained weekly orde monitored the client in Please see W104. This deficiency was of failed to implement a to prevent recurrence	I client #3's weight loss, red weights and/or n regard to his weight loss. ited on 7/3/13. The facility systemic plan of correction	{W 1	02}			
{W 104}		RNING BODY must exercise general policy, g direction over the facility.	{W 1	04}			
	Based on observation review for 1 of 2 sample additional client (#3), exercise general policy over the facility to ensure client #3 was the client's weight lost failed to exercise general policy and option over the facility to ensure the facility to ensure the form of all allegations of neconducted thorough is implemented corrective.	o the client's diabetes and to not neglected in regard to s. The governing body eral policy and operating litty to ensure the facility's the health care needs of g body failed to exercise perating direction over the facility initiated investigations eglect when informed,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		450045	D WING				R
		15G245	B. WING			08/	16/2013
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORI GIVE	100 BENTI TING IN GRANATION	IAG		DEFICIENCY)	VIE.	
{W 104}	Continued From page	2.5	{W 1	041			
(**,	Findings include:		(** '	0-1			
	Findings include.						
	1 The governing boo	dy failed to exercise general					
		direction over the facility to					
		plemented its written policy					
		event neglect of client #2's					
		ne interdisciplinary team					
	reviewed and/or addr	essed the client's elevated					
	blood sugar levels in	regard to the client's diet,					
		icate how client #2 would be					
	monitored at night in	•					
		w/high blood sugar levels to					
	ensure any change of						
		ed. The governing body					
	_	eral policy and operating					
		lity to ensure the facility					
		low and high blood sugar by the client's physician's					
	_	plan to ensure the facility's					
		the client's health needs in					
	regard to assessing the						
		ospital, to ensure nursing					
		hysician's orders as written,					
	and to ensure the clie	ent's physician was notified					
	of a hospitalization ar	nd/or notified the physician of					
	high blood sugar leve	I readings. The governing					
	body failed to exercis						
		er the facility to ensure the					
	-	informed/involved in the					
		process to assist the facility					
		client's elevated sugar					
		client's diet, and to develop					
	a risk plan for a medic						
		to exercise general policy on over the facility to ensure					
		ed its written policy and					
	procedures to ensure						
	·	an investigation was in allegation of neglect					
		the time of the incident. The					
	,		1				1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA I	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CO 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{W 104}	and operating direct the facility implement procedures to preveregard to the client's W149. 2. The governing be policy and operating ensure the facility in regard to an allegating regarding a medicat occurred and/or faile investigation into the #2. Please see W18. 3. The governing be policy and operating ensure the facility in corrective action to ever retrained in regulation please see W157. 4. The governing be policy and operating ensure the facility's repetitive action to ever retrained in regulation please see W157. 4. The governing be policy and operating ensure the facility's specifically indicated monitored at night in signs/symptoms of leensure any change immediately address facility's Health Care #2's low and high ble outlined by the clienty	d to exercise general policy ion over the facility to ensure ited its written policy and nt neglect of client #3 in weight loss. Please see ody failed to exercise general direction over the facility to itiated an investigation in on of possible neglect ion error, when the incident ited to conduct a thorough e allegation/incident for client	{W 1			
	over the facility to er Services met the clie	icy and operating direction sure the facility's Health Care ent's health needs in regard nt timely upon discharge				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		15G245	B. WING			08/	16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	C, THE		۷	STREET ADDRESS, CITY, STATE, ZIP CODE 1378 FOURTEENTH LN HOBART, IN 46342		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 104}	carried out physician's ensure the client's physician's ensure the client's physician's ensure the client's physician was informated interdisciplinary team to review/address the levels in regard to the body failed to exercise operating direction ov health care services of medical condition, reloss, obtained weekly monitored client #3 in loss. Please see W33. This deficiency was called to implement a to prevent recurrence	to ensure nursing services sorders as written, to sysician was notified of a notified the physician of I readings, and to ensure med/involved in the process to assist the facility client's elevated sugar client's diet. The governing e general policy and er the facility to ensure its developed a risk plan for a assessed client #3's weight ordered weights and/or regard to the client's weight it.	{W 1	104)			
{W 122}	Based on observation review, the facility fail Participation: Client Participation: Client Participation: (#2) at (#3). The facility faile policy and procedures regard to the clients' has been seen as the facility fails and procedures regard to the clients' has been seen as the facility fails and facility fails and facility fails are the facility fails and facility fails and facility fails are the facility fails and fails are the facility	ents are met. The that specific client ents are met.	{W 1	122)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY
		15G245	B. WING			R (40/2042
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	<u> </u>	16/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
{W 122}	in regard to an allega nursing medication er corrective actions we Findings include: 1. The facility failed the policy and procedure: #2's diabetes. The fainterdisciplinary teams the client's elevated by the client's diet. The specifically indicate he monitored at night in signs/symptoms of lovensure any change or immediately addressed monitor client #2's low readings as outlined for order and/or programensure the facility's niclient's health needs a client timely upon discontinuous ensure nursing ser orders as written. The client's physician was and/or notified the phelevel readings. The facility failed to implement its procedures to ensure interdisciplinary teams to review/address the levels in regard to the arisk plan for a medical failed to implement its procedures to ensure initiated in regard to a facility failed to implement interdisciplinary to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to a facility failed to implement its procedures to ensure initiated in regard to the facility failed to implement its procedures to ensure initiated in regard to the facility failed to implement its procedures to ensure initiated in regard to the facility failed to implement its procedures to ensure initiated i	tion of neglect in regard to a cror, and to ensure re followed. To implement its written is to prevent neglect of client cility failed to ensure the reviewed and/or addressed blood sugar levels in regard the facility failed to ow client #2 would be regard to the client's whigh blood sugar levels to fee condition could be red. The facility failed to wand high blood sugar by the client's physician's plan. The facility failed to ursing services met the in regard to assessing the charge from the hospital and vices carried out physician's refacility failed to ensure the charge from the hospitalization system of high blood sugar acility failed to ensure the charge from the process to assist the facility client's elevated sugar acility failed to ensure the definity of the condition. The facility section is detailed to develop call condition. The facility is written policy and	{W 12	2}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		15G245	B. WING				R 16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	IC, THE		4:	TREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN IOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 122}	W149. 2. The facility failed to regard to an allegation regarding a medication occurred and/or failed investigation into the #2. Please see W1543. The facility failed to corrective action to ensure the retrained in regardient #2. Please see This deficiency was confailed to implement a to prevent recurrence 9-3-2(a) 483.420(d)(1) STAFF. The facility must developlicies and procedure.	o initiate an investigation in n of possible neglect on error, when the incident of to conduct a thorough allegation/incident for client 4. o implement recommended insure all group home nurses and to hospital discharges for a W157. Sited on 7/3/13. The facility systemic plan of correction expenses and the correction of the wide of the wid	{W 1				
	Based on observation review for 1 of 2 sample additional client (#3), implement its written prevent neglect of clief acility neglected to esteam reviewed and/or elevated blood sugar client's diet. The facility reviewed and/or elevated blood sugar client's diet.	not met as evidenced by: n, interview and record pled clients (#2) and for 1 the facility neglected to policy and procedures to ent #2's diabetes. The nsure the interdisciplinary r addressed the client's levels in regard to the lity neglected to specifically would be monitored at night					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			R	
NAME OF PI	ROVIDER OR SUPPLIER	100240		STREET ADDRESS, CITY, STATE, ZIP COD		8/16/2013	
APC OF N	IORTHWEST INDIANA II	NC THE		4378 FOURTEENTH LN			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{W 149}	Continued From pag	e 10	{W 14	49}			
	in regard to the client low/high blood sugar of condition could be The facility neglected and high blood sugar client's physician's on The facility neglected nursing services met regard to assessing the discharge from the high services carried out put the facility neglected physician was notified the physician readings. The facility dietician was informed interdisciplinary teams to review/address the levels in regard to the arisk plan for a medineglected to implement procedures to ensure initiated in regard to a (medication error) at facility neglected to in and procedures to progard to the client's Findings include: 1. The facility's repound incident/Accident Reinvestigations were reported to incident/Accident Reinvestigations were reported in the facility's reported to incident/Accident Reinvestigations were reported to incident and incident reported to i	It's signs/symptoms of levels to ensure any change immediately addressed. It to monitor client #2's low readings as outlined by the reder and/or program plan. It to ensure the facility's the client's health needs in the client timely upon ospital and to ensure nursing physician's orders as written. It to ensure the client's dof a hospitalization and/or not flight blood sugar level of the process to assist the facility eclient's elevated sugar eclient's diet, and to develop ical condition. The facility ent its written policy and ean investigation was an allegation of neglect the time of the incident. The implement its written policy revent neglect of client #3 in weight loss. Table incident reports, ports (IAR) and/or eviewed on 8/12/13 at 3:23 cortable incident reports, ations indicated the following:					
	received a phone cal	I from the group home at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 08/16/2013	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{W 149}	gait was unsteady (s check his blood gluch nurse directed staff to [name of hospital] in tests and CT scan yi [Client #2] was not a was discharged from at 12:30 PM on 7/10, prescriptions for a way physician. At 1:00 PM Resident consumer [client #2] group home after ER disembarking the vel #2's] body shook und [client #2] to the group called[Client #2] was ER via ambulance. At 2:00 PM, the ER proceed (seizure) levels from initial visit). Consum Zalerate 100ml (milliing the ER to bring his different with the current med that [client #2] follow physician (PCP) and take his current med The facility's 7/19/13 client #2 saw his PC indicated client #2's and uncoordinated myith his diagnosis of	appeared lethargic and his ic). Staff were directed to ose level. It was 210. The otransport [client #2] to [name of city], In. Blood elded no significant findings. dmitted to the hospital, he the ER (emergency room) (13. No new medications, alker provided by the ER (alial staff transported from the hospital to the discharge. Upon nicle (at group home) [client controllably. Staff assisted and, no injury noted. 911 as transported back to the ohysician noted low Depakote previous work (taken at er [client #2] was given iters) intravenously while in epakote levels up. [Client from the ER at 5:00 PM on dications, prescription for a ER physician recommended tup with his primary care that [client #2] continue to ications as prescribed." follow-up report indicated P. The follow-up report 'increasing unsteadiness novements are correlated	{W 1-	49}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	` ′	(X3) DATE SURVEY COMPLETED		
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{W 149}	follow-up with a neur report also indicated physical therapist (P' (OT) for the need/use -7/11/13 "[Client #2] 9:00 AM with signs of sugar) which include combativeness. Heat tech tested [client #2] 369. [Client #2] was contacted Residential with Director of Healt closely monitored by changes. [Client #2' and tested at 463. Frand EMT (emergenciand checked [client #476. [Client #2] was hospital]." The facility's 7/17/13 client #2 followed up (diabetes specialist) changed the client's -7/26/13 "Consumer non-responsive during checked [client #2's] 40's, and the Nurse wand [client #2] was thospital]." -7/31/13 "[Client #2] [name of city], Indian 7/31/13. During the to show signs of hyp). It is recommended he ologist" The follow-up client #2 would see a T) and occupational therapist e of adaptive equipment. came into the workshop at f hyperglycemia (high blood d shakiness and alth & (and) Safety (H&S) 's] sugar level which was given water and H&S Tech all Nurse and left message th Services. [Client #2] was staff and H&S Tech for any so level was checked again acility Director called 911 y medical technician) arrived #2's] levels which tested at then transported to [name of follow-up report indicated with his Endocrinologist on 7/15/13 and the doctor insulin dosage.	{W 14	9}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			1	R 4€/2042	
	ROVIDER OR SUPPLIER			43	TREET ADDRESS, CITY, STATE, ZIP CODE 78 FOURTEENTH LN OBART, IN 46342	1 08/	16/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
{W 149}	His blood sugar was admitted to the hospital would not respond to name. The IAR indictive ER where it was level was below 30 a hospital. -8/5/13 "Director of Freviewed hospital diswhich instructed that to be checked prior to coverage was neede up and train day progorders. Which result his blood sugar checked and 8/6/13 (sic). The East center (facil provide Novolog insugucometer and test transcribed the order administration record safety tech on the need the least that the services will for the facility's 8/9/13 from the facility's 8/9/13 from hardone with the nurses review of all dischargall orders are carried.	ospital] emergency room. stabilized and he was tal for further observation." IAR indicated client #2 staff when they called his rated the client was taken to determined his blood sugar and he was admitted to the lealth Services (DHS) charge orders for [client #2], his blood sugar levels were to lunch to determine if insulined. The nurse failed to follow gram staff on the new doctor red in [client #2] not having ked appropriately on 8/5/13 re nurse immediately went to strips were available, so on the MAR (medication late), and trained the health and worders. The Director of collow up with [client #2's] an." Collow-up report indicated as are being implemented to opening again? Training was which consisted of thorough the hospital orders and ensure cout."	{W 1	49}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			08/	R 16/2013
	ROVIDER OR SUPPLIER	IC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		<u> </u>	.0.20.0
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 149}	Summary and Concluconducted an investigneglect. The facility's "[Client #2] was discheded as a proper summary and carried out; nurse did post-hospital D/C (dis 24 (hours) as per poli and train day program from M.D. (medical doinvestigation indicated. The facility's investigation indicated. The facility's investigation at temporal and the facility did no staffing agency until 8 witness statements in interviewed on 8/13/18/15/13 and Service (interviewed on 8/14/1. Administrative staff #3 statement indicated the medication error by the witness statement incomplete permission to the consumer and did not nown was about the consumer did not receives for the group hour stated she was good back to me with an upon what she told me serror, and process error, and process error initiated right awas staff #3) did not have	nvestigation Fact Sheet usion indicated the DHS gation in regard to possible investigation indicated larged home on Friday ospital orders were not not visit client for scharge) assessment within cy. Nurse failed to follow-up in staff on the new orders octor)." The facility's 8/8/13 d "The allegation is true." ation indicated LPN #1 was a ary nurse staffing agency, it report the allegation to the 3/13/13. The facility's adicated LPN #1 was 3, administrative staff #3 on Coordinator #1 was 3. 3's 8/15/13 witness hey were notified of a ne DHS on 8/6/13. The dicated "The Nursing at the Service Coordinator he hospital to discharge it inform the Residential sumer. She stated that the leive his insulin or glucose me and day service facility. Joing to look further and get odate. I told her that based so far it looked like a med forAn investigation was y because I (administrative knowledge of possible urse knowing about the	{W 1	49}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 08/16/2013	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	00/10/2013	
ADC OF N	ODTUWEST INDIANA IN	IC THE		4378 FOURTEENTH LN			
ARC OF N	ORTHWEST INDIANA IN	IC, THE		HOBART, IN 46342			
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{W 149}	Continued From page	e 15	{W 14	49}			
	internal investigation earlier,"	would have been initiated					
	statement indicated of received a phone call be discharged from the statement indicated Statement indicate	a and physician orders from ided them the fax number to less statement indicated SC of the discharge. The dicated the information PM and she gave the se for review. The witnessShe stated that it was okay led the Hospital Social d transportation w/ (with)					
	she was not told of cl hospital on 8/2/13. T indicated "staff repowould be returning Fr morning this nurse wafrom the hospital. The with paperwork and cowere sent to the groumanager, service cocclient was not seen we (hospital) discharge a sent to workshop (sicc with orders. Accordin Nursing) I was to be coclient according to poreceived the proper trepolicy and procedure	ness statement indicated ient #2's discharge from the he witness statement orted it was rumors client if (Friday). On Monday as informed client was home is nurse then follow-up (sic) larified MD orders, orders p home, workshop, area ordinators via email. The rithin 24 hours from hosp and although orders were) staff did not follow through ag to DON (Director of disciplined due to neglect of licy and procedure, I never raining, I never received a handbook. I no longer feel for a company that has no					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE	
structure and puts my jeopardy." The facilit neglected to interview group home staff in reand/or failed to initiate possible neglect on 8 was identified. The facility's training 8/12/13 at 4:00 PM. Individual Client Train DHS completed trainidischarge, reviewing orders and following medication changes with group homes. Interview with adminiat 4:15 PM indicated group home nurses. Indicated the DHS on worked with the Four Administrative staff # were not the only nur LPN #1 was a "tempor LPN #2 was a full time neglected to train all indischarge orders to eclients. During the 8/12/13 observed the staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not desensitization training the #2's record was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not was a staff #1 and #2 did not was a staff #1 and #2 did not desensitization training Client #2's record was a staff #1 and #2 did not was a st	y nursing license in y's 8/8/13 investigation of day program staff and egard to the error/incident, e an investigation for /5/13 once the error/incident records were reviewed on The facility's 8/5/13 sing Forms indicated the ng procedures for discharge orders, clarifying up with treatment and with LPN #1 and LPN #2 of strative staff #2 on 8/12/13 the DHS retrained 2 of 4 Administrative staff #2 ly trained the nurses who teenth Lane group home. 2 stated LPN #1 and LPN #2 ses who worked on call as orary" (part time) nurse and e nurse. The facility nurses in regard to nsure continuity of care with the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to the process of the stream of the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker. In the group home, client to belt and/or utilize a walker.	{W 1	49}				
	SUMMARY STA (EACH DEFICIENC REGULATORY OR IN Continued From page structure and puts my jeopardy." The facility neglected to interview group home staff in re and/or failed to initiate possible neglect on 8 was identified. The facility's training if 8/12/13 at 4:00 PM. Individual Client Train DHS completed traini discharge, reviewing orders and following if medication changes is the group homes. Interview with administ at 4:15 PM indicated group home nurses. In indicated the DHS on worked with the Fourt Administrative staff # were not the only nur LPN #1 was a "tempo LPN #2 was a full tim neglected to train all it discharge orders to e clients. During the 8/12/13 ob 5:15 PM and 7:10 PM #2 did not wear a gait Staff #1 and #2 did not desensitization trainin Client #2's record was 5:22 PM and on 8/13.	TORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 structure and puts my nursing license in jeopardy." The facility's 8/8/13 investigation neglected to interview day program staff and group home staff in regard to the error/incident, and/or failed to initiate an investigation for possible neglect on 8/5/13 once the error/incident was identified. The facility's training records were reviewed on 8/12/13 at 4:00 PM. The facility's 8/5/13 Individual Client Training Forms indicated the DHS completed training procedures for discharge, reviewing discharge orders, clarifying orders and following up with treatment and medication changes with LPN #1 and LPN #2 of the group homes. Interview with administrative staff #2 on 8/12/13 at 4:15 PM indicated the DHS retrained 2 of 4 group home nurses. Administrative staff #2 indicated the DHS only trained the nurses who worked with the Fourteenth Lane group home. Administrative staff #2 stated LPN #1 and LPN #2 were not the only nurses who worked on call as LPN #1 was a "temporary" (part time) nurse and LPN #2 was a full time nurse. The facility neglected to train all nurses in regard to discharge orders to ensure continuity of care with	TOURIDER OR SUPPLIER ORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 structure and puts my nursing license in jeopardy." The facility's 8/8/13 investigation neglected to interview day program staff and group home staff in regard to the error/incident, and/or failed to initiate an investigation for possible neglect on 8/5/13 once the error/incident was identified. The facility's training records were reviewed on 8/12/13 at 4:00 PM. 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Staff #1 and #2 did not implement any desensitization training with client #2. Client #2's record was reviewed on 8/12/13 at 5:22 PM and on 8/13/13 at 1:10 PM. Client #2's	TORRECTION SUPPLIER 15G245 15G245 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 structure and puts my nursing license in jeopardy." The facility's 8/8/13 investigation neglected to interview day program staff and group home staff in regard to the error/incident was identified. The facility's training records were reviewed on 8/12/13 at 4:10 PM. The facility's 8/5/13 Individual Client Training Forms indicated the DHS completed training procedures for discharge, reviewing discharge orders, clarifying orders and following up with treatment and medication changes with LPN #1 and LPN #2 of the group homes. Interview with administrative staff #2 on 8/12/13 at 4:15 PM indicated the DHS retrained 2 of 4 group home nurses. 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WING	TOTAL TOTAL NUMBER: 156245 156245 156245 156245 156245 15 WING STREET ADDRESS, CITY, STATE, 2IP CODE 4378 FOURTEENTH LN HOBART, IN 45342 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 16 Structure and puts my nursing license in jeopardy." The facility's 8/8/13 investigation neglected to interview day program staff and group home staff in regard to the emorificident, and/or failed to initiate an investigation for possible neglect on 8/5/13 once the emorificident was identified. The facility's training Forms indicated the DHS completed training procedures for discharge, reviewing discharge orders, clarifying orders and following up with treatment and medication changes with LPN #1 and LPN #2 of the group homes. Interview with administrative staff #2 indicated the DHS not provided with the Fourteenth Lane group home. 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Client #2's 5:22 PM and on 8/13/13 at 1:10 PM. Client #2's 5:22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			1	⋜ 16/2013
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{W 149}	indicated client #2's of not limited to, "Uncoo Parkinson Disease, a without control." The was to follow-up with "roller walker" was or #2's 7/10/13 lab report glucose level was 280 Valproic Acid level was second 7/10/13 ER not diagnosis included, be Convulsions." The section #2's seizures we Seizures." The attack Instructions indicated (NES) is a short period how you move, think, epileptic seizure, but changes in the brain. Early diagnosis and the prevent further problem. Client #2's 7/31/13 His indicated client #2 was chief complaint of Hylindicated "patient we diaphoresis (excessive associated with shock emergency conditions EEG done today; patiblood sugar. Hypogly past few days; had 3 The 7/31/13 H&P indicated insufficiency, most like effectWill consult [Inephrology"	lo/13. The 7/10/13 ER note liagnoses included, but were redinated movements, and Type II diabetes mellitus ER note indicated client #2 his PCP in 2 days and a dered for client #2. Client indicated client #2's at the ER and the client's as "22.5 (L)." Client #2's ote indicated client #2's ote indicated client #2's ut was not limited to, econd 7/10/13 note indicated ere "Non-Epileptic hed 7/10/13 Discharge "Non-epileptic seizure of of symptoms that change or feel. NES looks like an there are no electrical NES is a serious condition. reatment are needed to ems" Instory and Physical (H&P) as seen in the ER for the poglycemia. The H&P has reportedly developing the sweating commonly and other medical as) and restless while having the serious at local ER" Let visits at local ER" Let visits at local ER" Let visits at local ER" Let visits at local ER" Let visits at local ER" Let visits at local ER" Let visits at local ER" Let visits at local ER" Let visits at local ER" Let visits at local ER"	{W 1-	49}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		15G245	B. WING_			R 08/16/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2013
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{W 149}	8/2/13. The summar follow up with his PC nephrologist in 5 wee weeks. The 8/2/13 s was placed on a slidi summary indicated "C Novolog Mix 70/30 F skin 2 (two) times dai apart (sliding scale in Flex Pen inject three (blood sugar) 150-19 (subcutaneous) 200-249-2U SQ 250-300-3U SQ 301-349-4U SQ 350-400-5U SQ > (more than) 400-6 doctor)." The 8/2/13 indicated the facility viglucose levels 4 time bedtime (HS). The 8 indicated a doctor at medication changes, endocrinologist. Client #2's diagnosis limited to, "Chronic ki (moderately reduced Client #2's Cumulative physician orders indicinclusive): -7/10/13 "Sent to E.R.	to the group home on y indicated client #2 was to P in 1 week and the eks with labs to be done in 4 ummary indicated client #2 ng scale. The 8/2/13 Other Prescriptions lex pen inject 5 units into the illy before meals" and "insulin isulin coverage) Novolog times daily with meals BS 9 1U (unit) SQ units SQ call MD (medical Patient Instructions was to monitor client #2's s daily at meals and at /2/13 After Visit Summary the hospital made the not client #2's PCP and/or phrology report indicated included, but was not to idney disease, stage 3" kidney function). The Medical Records and cated the following (not all staff reporting (change) in	{W 14	19}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		15G245	B. WING			08/	16/2013	
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	C, THE		43	TREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN OBART, IN 46342			
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{W 149}	uncoordinated moven Type II DM (diabetes & CT head done. Rx Appt (appointment) (v (neurologist) 7-23-13 - 7-19-13 @ 9 AM." -7/11/13 "Gait belt DX -7/15/13 (8:25 AM) "E Status update given to office- Client taken to rec'd (received) to (in 20 units and p.m. dos office in 4 weeks- app 10:30 AM." -7/22/13 "Rec'd phone 7:15 pm- reports c (subcutaneous) given breathing/snoring lour informed to call 911 in Dextrose as per staff client aroused- no ER informed to give dinner this time; monitor con & call on-call nurse (v blood sugar 265- Cor throughout night." -7/23/13 "New Neur the request of the DO The Arc. Pt has been Disease. Pt was rece [name of hospital] for social worker here with the request of the position of the property of the property of the position of the property of the position of the property of the position of the posi	Iname of hospital] DX: nents, Parkinson Disease, mellitus), convulsions. Labs (prescription) for walker. vith) [name of doctor] @ 10 AM, Appt OT/PT eval ((diagnosis): unsteady gait." ((diagnose) the gait." ((diagnosed with 7-20-13 lient Bs 21 glucagen subcut produced subcut produ	{W 1	49}				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————		(X3) DATE SURVEY COMPLETED				
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	<u> </u>	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 149}	milligrams daily with the facility was to stathen 1 with breakfas with each meal. The the Neurologist orde asleep for client #2. client #2 was to return the 7/23/13 report in diagnosis of Seizure -7/23/13 "Spoke w/ (endocrinologist] re: (sugars over 300 and Dr. paged; orders reof endocrinologist] for phone; insulin increas (breakfast) and 20 ur (follow-up) for appt in -7/23/13 Faxed note call [name of endocrinologist] re: (lie) and the call [name of endocrinologist] for phone; insulin increas (breakfast) and 20 ur (follow-up) for appt in -7/23/13 Faxed note call [name of endocrinologist] re: (lie) and the call [name of endocrinologist] for phone; insulin increas (breakfast) and 20 ur (follow-up) for appt in -7/23/13 Faxed note call [name of endocrinologist] for endocrinologist] for endocrinologist and the facility's note and the facility is not and the facility's note and the facility's note and the facility is not and the facility is not and the facility is not an and the facility is not an analysis of the	a (Parkinson Disease) 25-100 meals. The note indicated art with breakfast for 1 week, then 1 e neurology report indicated and EEG awake and The report also indicated an in 6 weeks or as needed. Indicated client #2 was given a	{W 14	19}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		15G245	B. WING			R 08/16/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		00/16/2013
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{W 149}	Continued From page	e 21	{W 14	9}		
	outing. B.S. 53 wher (subcutaneous) gluca supper @ outing arour repeat BS in 1 hourup to 98 informed to grackers & cup of mill—undated note "In case emergency room of the and have [name of enumber listed] wait for your number with a to two beeps again. The endocrinologist] wall result of the properties of the propert	se of emergency go to the he hospital closest to you indocrinologist] paged [pager or two beeps then place in buch tone phone. Then wait en hang up. [Name of teturn your call. [Name o				
		blood sugar below 30. The #2 was to have a kidney I work completed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2010
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(W 149)	Continued From pag	ge 22	{W 14	49}		
	return. Client alert of responsive. 0 (zero (respirations) even of lung sounds clear, by W/D intact. V/S (vit received et noted. (name of PCP] in 1 5 wks." The facility upon discharge from ensure the new order. B/12/13 Client #2 strong follow-up to the 7/3 Client #2's 7/19/13 indicated client #2 vexercise safety arout objects. The assess "unable to follow (sic)" The PT ass Home Program: pt i exercises. No HEP provided/Pt inappropriateReco **Requires OT follow appropriate for OT secommend 24 hout environment. This proccupational therap independence with Client #2's 8/5/13 Mindicated client #2 hours of the Novolog 70/30 5 un breakfast and dinner.	client post hosp (hospital) et (and) non verbally et (blateral) et owels active x 4 quads, skin al signs) stable, new orders Client to follow up (with) wk et [name of Neurologist] in neglected to assess client #2 in the hospital on 8/2/13 and/or ers were implemented. Et and OT evaluation was a fall risk and should und sharp objects or moving esment indicated client #2 was a step commands consistantly esesment indicated "Current es unable to follow any (home exercise program) end up**: No PT is not eservices at this time. Eur supervision in structured estatient will be seen for skilled by for optimal return to end an ew medication end an ew medication end an ew medication end an ew medicated "Give end and an ew medicated "Give end and an ew medicated "Give end and an ew medicated "Give end an ew medication end and an ew medication end and end e				

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{W 149}	Nurse/MD" The 8/5/13 change fo Medical Record indica obtain clarification in and/or endocrinologis the 7/23/13 order indicated 400. Client #2's August 20 Administration Record facility monitored clien the morning, lunch, P and at bed time. Clie	rm and/or Cumulative atted the facility neglected to regard to when the doctor at wanted to be notified as cated at 300 and the 8/5/13 13 Medication (MARs) indicated the nt #2's blood sugar levels in M (evening before dinner) nt #2's 8/13 MAR indicated agar levels (not all inclusive): er 342 er 310 er 321 her 435	{W ·	149				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{W 149}	Continued From page	e 24	{W 1	49}			
{w 149}	The facility's Residen was reviewed on 8/13 facility's pager record regards to client #2's -7/8/13 302 at 5:55 Pland shaking." -7/18/13 352 at 8:07 /-7/18/13 353 at 6:12 Idifferent glucometer. -7/22/13 408 at 5:53 Idifferent glucometer. -7/24/13 330 at 9:18 Idifferent glucometer. -7/24/13 348 at 6:30 Idifferent glucometer. -7/27/13 487 at 6:30 Idifferent glucometer. -8/24/13 398 at 6:20 Idifferent glucometer. -8/2/13 398 at 6:20 Idifferent glucometer. -8/2/13 398 at 6:20 Idifferent glucometer. -8/2/13 398 at 6:30 Idifferent glucometer. -8/2/13 398 at 6:30 Idifferent glucometer. -8/2/13 398 at 6:50 Idifferent glucometer. -8/2/13 398 at 6:50 Idifferent glucometer. -8/2/13 304 at 10:31 Idifferent glucometer.	tial Services Pager Review 3/13 at 1:40 PM. The s indicated the following in blood sugar levels/readings: M, client #2 was "unsteady AM PM, and then 379 with a PM	{W 1	49}			
		endocrinologist of client readings over 300 prior to					
	#2 was to carry a sac	rped sheet indicated client k lunch and a snack to the ocument what was sent and					
	client #2 received an	od journal book indicated 1800 calorie ADA (diabetic) 13 menus indicated "Hot o" on 8/8/13, 8/9/13,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{W 149}	8/23/13, 8/26/13, 8/26 Client #2's 8/2013 for following menu/food i lunch on the following -8/8/13 Three ounces macaroni and cheese bread, orange slices a -8/9/13 Three ounces noodles, garlic bread carrots, 1 cup manda ounce cup of milk. -8/11/13 Three ounce dirty rice, 1/2 bun, sal water. -8/12/13 2 sliced hot a serving of rice, 1 serving of rice, 1 serving of rice, 1 serving of rice, 1 serving and crackers and Client #2's 1800 calor facility neglected to hidevelop and/or approsack lunch menus for menu indicated the fa an approved sack lundays of 8/15/13, 8/16, 8/23/13, 8/26/13, 8/26 Client #2's 6/5/13 Antindicated "Client on plan as ordered by Micarbohydrate counting monitor blood sugar."	6/13, 8/19/13, 8/22/13, 8/13 and 8/30/13. od journal book indicated the tems sent for the client's grays: of chicken, 1/2 cup e, 1/2 cup potatoes, 1 slice of and water. of meat, 1/2 cup of 1/2 cup of 1/2 cup of peas and rin oranges, water and 8 os of polish sausage, 1/2 cup lad, fruit cup, yogurt and 1/2 cup of salad, fruit cup, 1/2 cup of bread, 1 cling of salad, fruit cup, 1/2 cup of salad, fruit cup, 1/2 cup of salad, fruit cup, 1/2 cup of bread, 1 client #2. Client #2's 8/13 ocility neglected to develop 1/2 client #2. Client #2's 8/13 ocility neglected to develop 1/3, 8/19/13, 8/22/13, 1/2 and 8/30/13.	{W 1	49}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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{W 149}	The facility neglecte calorie ADA diet re-a client's high/low block menus did not conta carbohydrates and/caffect client #2's block Client #2's 8/7/13 Di	ped by the group home staff. d to have client #2's 1800 assessed in regard to the od sugar levels to ensure the in a lot of starches, or natural sugars which could od sugar levels. abetic (risk) Plan indicated	{W 149	}			
	for review for approving risk plan indicated of lunch daily. The 8/7 "During sleep ched in bed as he may be sweat through his cliblood sugar. If blood for the following symular experience of the following sy	ed and sent to the Nutritionist val and revisions." The 8/7/13 ient #2 was to carry a sack /13 risk plan indicated ck for crying out or thrashing having nightmares. He may othing. If noted check his d sugar is above 400 check aptoms (Hyperglycemia)					
	100units/ml injection sliding scale MD ord sugar is above 400 of flexpen should be accale MD orders and notify MDIf 911 is should be completed	ıth					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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{W 149}	regard to the client's blood sugar levels to condition could be im Client #2's 7/2013 ris Syndrome indicated "#2] while ambulating that [client #2] and the dried after showering sure walkways are clehazards[Client #2] I belt and walker. How combative in using the walker. A desensitized developed please see 7/2013 risk plan indices specifically indicate we use the gait belt, and staff were to keep the gait was unsteady. Client #2's 7/13 behabelt and walker has (see [client #2] to reduce the facility neglected plan for the client's Chient #2's 7/13 behabelt and walker has (see [client #2] to reduce the for this is being added also resistant to these item for the desensitization for apadded (sic). Client #2 indicated the desensitiand the walker were stand the walker were stand the walker were stand the group of	nonitor client #2 at night in signs/symptoms of low/high ensure any change of mediately addressed. It plan for Parkinson's a staff will to monitor [client (sic)Staff will make sure to be bathroom floor are fully and been prescribed a gait are ever, at this time he is the gate (sic) belt and the ation plan has been to the staff should attempt to a client safe when the client's ated the facility neglected to address/develop a risk thronic Kidney Disease. In the sextremely the se	{W 1	49}					
	Client #2's 2/28/13 IP	PP indicated client #2's							

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA	DATE
{W 149}	7/11/13 and on 7/19/mentioned IDT notes IPP indicated the IDT client #2 was dischar 8/2/13 to review and/the client's risk plans and/or record indicate ensure the dietician at the IDT meetings. C indicated the facility r#2's 1800 calorie AD regard to the client's readings/levels to decorrelation. Interview with staff # at 6:41 PM when ask transported to the hostated client #2 would hospital when the clie#1 stated client #2's was "significant-irreg client #2 was monitor blood sugar/sympton him every hour when she did not work mid Interview with the die by phone, indicated sthe month of May 20 facility had contacted elevated and low blothe dietician stated "I she was not aware client #2 was diagnostical inservice training. We client #2 was diagnostical inservice training. We client #2 was diagnostical indicated was diagnostical inservice training. We client #2 was diagnostical indicated was diagnostical inservice training. We client #2 was diagnostical inservice was diagnostical indicated was diagnostical inservice training. We client #2 was diagnostical inservice was diagnostical ins	(IDT) met on 7/10/13, 13. Client #2's above and/or the client's 2/28/13 in eglected to meet since ged from the hospital on or make needed changes to Client #2's 2/28/13 IPP ed the facility neglected to and/or input was included in ient #2's IPP and/or record neglected to review client A diet menus/food journals in high/low blood sugar termine if there was any 1, #2 and SC #1 on 8/12/13 ed when client #2 would be spital, staff #1 and SC #1 d be transported to the ent was "unresponsive." SC doctor would be called if it ularities." When asked how red at night in regard to his ns, staff #1 stated "I check I work." Staff #2 indicated nights. tician on 8/13/13 at 1:44 PM, she last assessed client #2 in 13. When asked if the her in regard to the client's od sugar levels and his diet, No." The dietician indicated	{W 1	49}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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{W 149}	insulin changes from The dietician stated be notified in regard in medication, diet or re-evaluate client." should be made aw readings" which we stated she did not a had discussed the opast. The dietician communicated with to the client's menureviewed and approwere sent to her. Tracility had not asked Interview with admin #2, and the DHS on client #2 was hospith blood sugar level rethe hospital for an Eclient #2 was dischart a sliding scale. The order for the changen otification. The DH sugar levels were "tracility indicated the dietical low and high blood DHS indicated clien lunches July 28, 20 meals at the workshindicated they had rensure all lunches happroved by the die 8/2013 menu was aclient #2 was still earlier was still earlier #2 was still #2 was s	he was not aware of any in the 7/31/13 hospitalization. she would "Definitely want to it to low blood sugar or change changes to go back and The dietician stated she are of any "abnormal re high or low. The dietician ttend the IDT meetings but client's "Plan of Care" in the indicated she had not the Endocrinologist in regard in the Endocrinologist in regard in the dietician indicated she wed the client's menus that the dietician indicated the indicated in 7/31/13 for low adding when the client was at EEG. The DHS indicated arged on 8/2/13 and placed on it DHS could not locate the indicated client #2's blood in and down." The DHS in was aware of client #2's sugar level readings. The it #2 started carrying sack it yersus purchasing hot inops. The DHS and SC #1 indicated the proved by the dietician when inting at the workshop. SC #1 indicated menus for the inting at the workshop. SC #1 indicated menus for the	{W 14					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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{W 149}	the menus since to The DHS, SC #1 and indicated the dietic meetings. SC #1 inviting the dietician SC #1 and #2 indicated diabetes function. SC #1 add not have a risk SC #1 and #2 indicated client #2 using his walker a had trained the day desensitization plagroup home staff in The DHS indicated.	age 30 #1 indicated no one reviewed he dietician approved them. and administrative staff #2 cian had not attended any IDT stated "No one thought of an to the program (meetings)." cated there had been no note 7/19/13. The DHS indicated et client #2 had a diagnosis of sease stage 3. The DHS could affect the kidneys and the DHS indicated client #2 kiplan for his new diagnosis. Cated client #2 did not want to and/or use a walker. SC #2 had a desensitization plan for and gait belt. SC #2 indicated he by program staff in regard to the an, but he had not trained the n regard to the behavior plan. diclient #2 had a diagnosis of et. The DHS indicated the	{W 1		(IENCY)		
	indicated client #2 for a walker but a place. When aske client #2 safe as the gait belt, SC #1, the #2 indicated the II in place. The DHS Endocrinologist whow and high bloom the doctor would repages/calls. The the doctor on 7/23 his office, the pag DHS indicated the notified if client #2	valuation by the OT and PT would not be a good candidate gait belt had been put into ed how the facility was keeping he client did not want to utilize a he DHS and administrative staff OT would need to put something S indicated client #2's has made aware of client #2's d sugars. The DHS indicated hot always return his DHS indicated she spoke with hi/13 and nursing staff was to call her and/or his cell phone. The he doctor still wanted to be 's blood sugar levels were over dicated she was not aware the					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
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{W 149}	8/2/13 discharge order notification to 400. The facility's nurse should the order to notify the sugar levels over 300 facility's nurse notified following high blood so "no (to each one)" as documentation the do -7/8/13 302 at 5:55 PI -7/18/13 352 at 8:07 A -7/18/13 353 at 6:12 Fi different glucometer7/22/13 408 at 5:53 Fi -7/24/13 330 at 9:18 Fi -7/27/13 487 at 6:30 Fi -7/28/13 bed time 328 -8/3/13 lunch 444 -8/3/13 bed time 312 -8/4/13 bed time 341 -8/5/13 morning 304 -8/5/13 evening/dinne -8/6/13 evening/dinne -8/10/13 evening/dinne -8/10/13 evening/dinne -8/10/13 evening/dinne -8/10/13 evening/dinne -8/10/13 bed time 371 -8/11/13 lunch 344 -8/11/13 evening/dinne -8/10/13 bed time 371 -8/11/13 lunch 344 -8/11/13 evening/dinne -8/10/13 bed time 371 -8/11/13 bed time 352 The DHS indicated the called in regard to blo The DHS, SC #1 and IPP did not specificall were to monitor the cl	ers had changed the he DHS indicated the have sought clarification of doctor of client #2's blood or 400. When asked if the d the doctor of client #2's rugar levels, the DHS stated there was no octor was called: MAM PM, and then 379 with a PM	{W ·	1149			
		d SC #1 indicated the IDT					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{W 149}	Continued From page	e 32	{W 1	49}			
	had not re-assessed journal/consumption i and/or high blood sug	n regard to the client's low					
	1:45 PM, by phone, in patient he followed. Indicated he saw clier The doctor indicated over 400 in his office. indicated when he as #2's morning blood su Endocrinologist indicated him. The Endocrinologist indicated him. The Endocrinologist indicated freadings with them extractional the doctor indicated fregard to the client's in Endocrinologist indicated regard to the client's in Endocrinologist indicated fregard to the client's in Endocrinologist indicated fregard to the client's in Endocrinologist indicated him. When asked #2's hospitalization, the when client #2 was he Endocrinologist indicated #2 had been hospitalistated "I requested to hospitalizations. I recollood sugar levels." Indicated he wanted to blood sugar levels we had been changed to indicated they should were over 300. The Endocrinologist to the sugar levels we had written orders to	Int #2 at his office on 8/15/13. Client #2's blood sugar level The Endocrinologist ked the nurse what client ugar reading was, the ated the nurse could not tell ogist stated he had written blood sugar levels to be cility did not bring all the except the "PM readings." The made some changes in insulin on 8/15/13. The ated the nurse told him the except get he client for his stated he told them the diabetes and if his PCP bey could bring the client back if he was aware of client the Endocrinologist asked pospitalized and why. The ated he was not aware client in the Endocrinologist call him when the levels Endocrinologist indicated he					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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{W 149}	"They have not show The Endocrinologist is the facility was not me sugar levels as order." Interview with LPN #2 and #2 on 8/15/13 at saw the endocrinology. Administrative staff #2 know she was to take appointment as the Dout the DHS had resist LPN #2 indicated cliewas 432 at the doctor given 15 units of Novo office. When asked we to the appointment, a indicated LPN #2 was sugar levels as they windicated she took the level readings only. It take the AM readings for the doctor to reviet took client #2's menuclient's lunch on hand indicated she had clied doctor did not look at endocrinologist had be client's hospitalization. LPN was told to call the endocrinologist the endocrinologist the endocrinologist had be client's hospitalization. LPN was told to call the endocrinologist had be considered the doctor whospitalization. LPN was told to call the endocrinologist had the considered she had client's hospitalization. LPN was told to call the endocrinologist had the considered she had client's hospitalization. LPN was told to call the endocrinologist had the considered she had client's hospitalization. LPN was told to call the endocrinologist had the considered she had client's hospitalization.	ne Endocrinologist stated in me any food journals." Indicated he was concerned onitoring client #2's blood ed. 2 and administrative staff #1 2:30 PM indicated client #2 ist on 8/15/13. 1 indicated LPN #2 did not eclient #2 to the doctor's ellent #2 to the doctor's ellent was to take the client gned the morning of 8/15/13. In #2's blood sugar level r's office and the client was olog 70/30 at the doctor's what documents were taken dministrative staff #1 is not able to take the blood were not available. LPN #2 in time blood sugar LPN #2 indicated she did not per linch time blood sugar LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 indicated she for today 8/15/13 and the for 8/15/13 indicated she for today 8/15/13 and the for 8/15/13 indicated she for today 8/15/13 indicated she for	{W 1-			
	on 25 units Novolog a supper. LPN #2 indic	scale and placed client #2 state and placed client #2 at breakfast and 20 units at cated nursing staff were to 24 hours of discharge from				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		450045	D WING				R
		15G245	B. WING _			08/	16/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE		
ARC OF N	ORTHWEST INDIANA IN	IC, THE		4378 FOUR HOBART,	RTEENTH LN IN 46342		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{W 149}	Continued From page	e 34	{W 1	49}			
	previous nurse did no client #2. Administra investigation was dor investigation was to b	oe done. They said no. old them this should be					
	at 2:30 PM and on 8/nursing staff would se change form to the gradient of the	1 indicated nursing staff had client once discharged from the facility's policy. 1 indicated an investigation fard to the 8/5/13 allegation of client #2's discharge from the orders. Administrative group home checked client at lunch and administered the sliding scale as needed the sliding scale as needed the staff called the orders sent home with the from what the client had nospitalization. 1 stated the on-call nurse the staff #1 indicated this					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15G245	B. WING_			R 08/16/2013		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 4378 FOURTEENTH LN HOBART, IN 46342		00/16/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
{W 149}	#1 indicated on 8/2/13 going to the group ho Administrative staff # longer employed with 2. A review of client at the facility's admini 2:30 P.M Review of a "Nutritional Assessr indicated: "Weight: 1 Weight: 169-186Di Review of client #3's indicated the following Medical notation date of colon wall thickenin Weight loss continued down additional 8 1/2 recommend colonosc note came up medical assess increase calor Medical notation date [Physician name] spot for nutritional supplementation of the commendations for testing further evaluated Medical notation date entryAppointment to visit with [Physician name] called this writ anything about his weight Medical notation date name] called this writ anything about his weight Medical notation date	3, "She (LPN #1) was not me at 4:00 PM." 1 indicated LPN #1 was no the facility. #3's record was conducted strative office on 8/13/13 at folient #3's record indicated ment" dated 6/5/13 which 59 lbs (pounds)Ideal Body et Order: Regular Diet." "Cumulative Medical" record g: d 7/25/13: "Multiple areas ng, possible mass or colitis. s now at 152.5 pounds, pounds. Strongly opy/lower GI testingOf iid ineligible todayAlso ries." d 7/31/13: "Called ke to [Nurse name] orders nentto have weights d 7/31/13: "Late to be scheduled for follow-up ame] re: weight loss colonoscopy/lower GI tions." d 8/2/13: "[Client #3 Aunt erstated nobody is doing	{W 1-	49}				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		15G245	B. WING			R 08/16/2013	
NAME OF P	ROVIDER OR SUPPLIER	100-10			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2013
ADC OF A	ODTIMEST INDIANA IN	IC TUE		4	1378 FOURTEENTH LN		
ARC OF N	ORTHWEST INDIANA IN	IC, THE		ŀ	HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 149}	100% of all meals and Weekly weights will of Client #3's 2012 and at the following (not all in -May 2012 2012 -June 2012 10-August 2012 10-August 2012 10-August 2012 10-August 2012 10-August 2012 10-August 2013 10-Au	s. Consumer consume d ensure supplement. ontinue." 2013 Weight Chart indicated inclusive): 29 pounds 19 pounds 88 pounds 88 pounds 83 pounds 86 pounds 67 pounds 67 pounds 67 pounds 68 pounds 67 pounds 67 pounds 68 pounds 69 pounds 60 pounds	{W 1	49}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			C	X3) DATE S COMPLI	
		15G245	B. WING _			R 08/16/2013	
	ROVIDER OR SUPPLIER	C, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	E	(X5) COMPLETION DATE
{W 149}	risk plan indicated clie once a week at the da indicated the Health & the weights and send The 5/2013 risk plan is 3lbs (pounds) in a we Nurse will evaluate the client's doctor. The ri would keep a record consumption. A review of the Direct weights spread sheet conducted on 8/14/13 the spreadsheet indice monthly. The spread client #3 was weighed. An interview with the (DON) was conducted administrative office of When asked how offer the DON stated "Mon was documentation to weighed weekly, the latthe day program are send the information on my spin her documented spre was weighed weekly, When asked if client is had been addressed loss noted on 7/25/13 sure." When asked if	teets at least monthly. The ent #3 would be weighed ay program. The risk plan is Safety Tech would monitor them into the nurse weekly. Indicated "If plus or minus ek the Community Services in findings" and contact the sk plan indicated the nurse of client #3's food or of Nursing services client in date noted was at 1:30 P.M Review of ated client #3 was weighed sheet neglected to indicate in weekly. Director of Nursing services dient the facility's in 8/14/13 at 2:30 P.M in client #3 was weighed, thly." When asked if there in indicate client #3 was DON stated "He is weighed in when they weigh him they to me and I put the read sheet." When asked if ad sheet indicated client #3 is he stated "No, monthly." #3's weight loss risk plan is since his 8.5 pound weight in the DON stated "I'm not the doctor or nutritionist after the noted weight loss, not sure."	{W 14	49}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		15G245	B. WING _			R / 16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	IC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
{W 149}	2/15/12 policy entitled of Neglect And Abuse Northwest Indiana pro exploitation of our clie abuse, neglect, humil investigated per The investigation process individual." The facilities defined as failure the safety or care of the remedy the placing of poses a threat to his/Examples include, but care/treatment," This deficiency was of failed to implement a to prevent recurrence and to prevent recurrence generally as a second of the facility must have violations are thorough. This STANDARD is a Based on 1 of 1 allegoneglect reviewed, the investigation in regarding a mincident occurred and	at 2:33 PM. The facility's display Policy For Handling Cases indicated "l. The Arc polibits all abuse, neglect and entsIII. All allegations of iation or exploitation will be Arc Northwest Indiana's while protecting the ty's policy indicated "Neglect to consider and provide for the client and anticipate and for a client in a situation that ther health and well-being. It are not limited tomedical ited on 7/3/13. The facility systemic plan of correction to the evidence that all alleged.	{W 1			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP COD 4378 FOURTEENTH LN HOBART, IN 46342	E	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
W 154	PM. The facility's 8/report indicated "Dir (DHS) reviewed hos [client #2], which ins levels were to be ch determine if insuling nurse failed to follow staff on the new doc [client #2] not having appropriately on 8/5 nurse immediately wowned day program ensured that the glu available, transcribe (medication administ the health and safet The Director of Heal [client #2's] primary The facility's 8/9/13 "3. What measure prevent this from had done with the nurse review of all discharall orders are carried."	ble incident reports, eports (IAR) and/or reviewed on 8/12/13 at 3:23 is 5/13 reportable incident ector of Health Services epital discharge orders for atructed that his blood sugar ecked prior to lunch to coverage was needed. The vup and train day program attor orders. Which resulted in ghis blood sugar checked in ghis blood sugar check	W			
	Summary and Conc conducted an invest neglect. The facility "[Client #2] was disc	Investigation Fact Sheet Iusion indicated the DHS igation in regard to possible 's investigation indicated charged home on Friday nospital orders were not d not visit client for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED
	15G245	B. WING _			R 08/16/2013
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC	s, THE		STREET ADDRESS, CITY, STATE, ZIP COL 4378 FOURTEENTH LN HOBART, IN 46342	I	00/10/2013
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE
24 (hours) as per policiand train day program from M.D. (medical docinvestigation indicated The facility's investigat nurse from a temporary and the facility did not staffing agency until 8/ witness statements indinterviewed on 8/13/13 8/15/13, and Service Conterviewed on 8/14/13 Administrative staff #3' statement indicated the medication error by the witness statement indicated that gave permission to the consumer and did not in Nurse about the consumer did not receivests for the group hom She stated she was good back to me with an upon what she told me so error, and process error not initiated right away staff #3) did not have kneglect of the temp nurdischarge of this consumernal investigation we earlier,"	charge) assessment within y. Nurse failed to follow-up staff on the new orders ctor)." The facility's 8/8/13 "The allegation is true." ion indicated LPN #1 was a y nurse staffing agency, report the allegation to the 13/13. The facility's licated LPN #1 was a, administrative staff #3 on coordinator #1 was a, administrative coordinator #1 was a believed as a DHS on 8/6/13. The cated "The Nursing the Service Coordinator and the coordinator are coordinator and the service Coordinator and the service facility. Sing to look further and get date. I told her that based of far it looked like a med forAn investigation was because I (administrative knowledge of possible rise knowing about the	W 1	54		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15G245	B. WING			R 08/16/2013	
NAME OF P	ROVIDER OR SUPPLIER	100210		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 06/	16/2013
ARC OF N	IORTHWEST INDIANA IN	C, THE			B FOURTEENTH LN BART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 154	Continued From page	÷ 41	W.	154			
W 134	statement indicated S discharge information the hospital and provi the facility. The witnes #1 then told LPN #1 witness statement incarrived by fax at 4:15 information to the nur statement indicated " and I (SC #1) contact Worker and schedule [name of ambulance LPN #1's 8/13/13 witr she was not told of cli hospital on 8/2/13. Tindicated " staff repowould be returning Fr morning this nurse was from the hospital. Th with paperwork and cowere sent to the groumanager, service cooclient was not seen w (hospital) discharge a sent to workshop (sic with orders. Accordin Nursing) I was to be colient according to poreceived the proper troplicy and procedure comfortable working for structure and puts my jeopardy." The facility indicated the facility for program staff and grothe error/incident, and	and physician orders from ded them the fax number to less statement indicated SC of the discharge. The licated the information PM and she gave the se for review. The witness She stated that it was okay led the Hospital Social discontained transportation w/ (with) company]." The sess statement indicated lent #2's discharge from the line witness statement orted it was rumors client in (Friday). On Monday less informed client was home its nurse then follow-up (sic) larified MD orders, orders phome, workshop, area ordinators via email. The lithin 24 hours from hospind although orders were less than though orders were less than than the less than than the less than than the less than than than the less than than than than the less than than than than the less than than than than than the less than than than than than than than than		194			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA	INC, THE		STREET ADDRESS, CITY, STATE, ZIP COI 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 154	Continued From page	ge 42	W	154		
	at 4:15 PM when as investigation for the administrative staff told no investigation seen as an allegation	8/5/13 incident, #2 indicated she had been was completed as it was not on of neglect.				
	at 2:30 PM and on 8 nursing staff would schange form to the medications were classified the present indicated the present staff #1 stated "An indetermine if an investigation. When should be investigated.	nistrative staff #1 on 8/15/13 8/16/13 at 10:50 AM indicated send the medication/order group home when clients' nanged. Administrative staff vious nurse did not do a of client #2. Administrative nvestigation was done to stigation was to be done. In came to me I told them this sed as neglect."				
	the group home per Administrative staff was conducted in re of neglect in regard the hospital/physicia staff #1 indicated th #2's blood sugar lev client #2's insulin pe on 8/3, 8/4, 8/5 and #1 indicated the gro on-call nurse as the client were different received prior to the	#1 indicated an investigation agard to the 8/5/13 allegation to client #2's discharge from an's orders. Administrative a group home checked client at lunch and administered at the sliding scale as needed 8/6/13. Administrative staff up home staff called the orders sent home with the from what the client had a hospitalization.				
	"walked them throug MAR." Administrati information was not	#1 stated the on-call nurse gh writing the orders on the we staff #1 indicated this documented in the nistrative staff #1 stated LPN				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		15G245	B. WING			R 08/16/2013
	ROVIDER OR SUPPLIER	IC, THE		STREET ADDRESS, CITY, STATE, 2 4378 FOURTEENTH LN HOBART, IN 46342	ZIP CODE	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		DATE
W 154	going to the group ho	3, "She (LPN #1) was not me at 4:00 PM." 1 indicated LPN #1 was no	W -	154		
W 157	483.420(d)(4) STAFF	TREATMENT OF CLIENTS is verified, appropriate t be taken.	W	157		
	Based on interview a allegation of abuse al facility failed to imple corrective action to el	not met as evidenced by: and record review for 1 of 1 and/or neglect reviewed, the ment recommended assure all group home nurses and to hospital discharges for				
	The facility's 8/5/13 re indicated "Director of reviewed hospital diswhich instructed that to be checked prior to coverage was needeup and train day progorders. Which resulte his blood sugar check and 8/6/13 (sic). The	ports (IAR) and/or eviewed on 8/12/13 3:23 PM. eportable incident report Health Services (DHS) charge orders for [client #2], his blood sugar levels were blunch to determine if insulined. The nurse failed to follow ram staff on the new doctor ed in [client #2] not having ked appropriately on 8/5/13 nurse immediately went to ty owned day program) to lin, ensured that the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		15G245	B. WING			R 8/ 16/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 157	administration record safety tech on the ne Health Services will find primary care physician. The facility's 8/9/13 for "3. What measures prevent this from hap done with the nurses review of all dischargiall orders are carried. The facility's 8/5/13 lanurse involved in the The facility's training 8/12/13 at 4:00 PM. Individual Client Train DHS completed train discharge, reviewing orders and following medication changes the group homes. Interview with adminiat 4:15 PM indicated group home nurses. Indicated he DHS on worked with the Four Administrative staff # were not the only nur LPN #1 was a "tempor LPN #2 was a full time."	s on the MAR (medication), and trained the health and w orders. The Director of ollow up with [client #2's] an." ollow-up report indicated are being implemented to opening again? Training was which consisted of thorough e hospital orders and ensure out." AR indicated LPN #1 was the error. records were reviewed on The facility's 8/5/13 aning Forms indicated the ing procedures for discharge orders, clarifying up with treatment and with LPN #1 and LPN #2 of strative staff #2 on 8/12/13 the DHS retrained 2 of 4 Administrative staff #2 ly trained the nurses who teenth Lane group home. 2 stated LPN #1 and LPN #2 ses who worked on call as orary" (part time) nurse and lie nurse. The facility failed egard to discharge orders to	W 1	57		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		15G245	B. WING			R 08/16/2013
	ROVIDER OR SUPPLIER	IC, THE		STREET ADDRESS, 4378 FOURTEENTH HOBART, IN 463		1 00/10/2013
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W 189 W 189	The facility must provinitial and continuing	TRAINING PROGRAM ride each employee with training that enables the his or her duties effectively,	W 1			
	Based on observation review for 1 of 2 sam failed to ensure all gr	not met as evidenced by: n, interview and record pled clients (#2), the facility oup home staff were trained 's desensitization plan for or walker.				
	The facility's reportable Incident/Accident Reprinvestigations were read to facility's reportable and/or investigations. Service Coordinator (phone call from the graph and for investigations) and for investigations. Service Coordinator (phone call from the graph and for investigations) and for investigations are investigations. The formation investigation and for investigations and for i	corts (IAR) and/or eviewed on 8/12/13 3:23 PM. oble incident reports, IARs indicated on 7/10/13 "This ISC) (SC #1) received a roup home at approximately stated that consumer [client ic and his gait was unsteady obtained to check his blood 210. The nurse directed in t#2] to [name of hospital] Blood tests and CT scan findings. [Client #2] was not tal, he was discharged from from a tal, prescriptions for a le ER physician.				
	At 1:00 PM Residenti consumer [client #2] group home after ER	from the hospital to the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X	3) DATE SURVEY COMPLETED		
		15G245	B. WING			R 08/16/2013		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342			1 00/16/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
W 189	disembarking the ve #2's] body shook und [client #2] to the grout called[Client #2] wo ER via ambulance. At 2:00 PM, the ER p (seizure) levels from initial visit). Consum Zalerate 100ml (millidate the ER to bring his date #2] was discharged to 7/10/13. No new me walker written. The that [client #2] follow physician (PCP) and take his current med The facility's 7/19/13 client #2 saw his PC indicated client #2's and uncoordinated n with his diagnosis of (disorder of the brain and difficulty walking follow-up with a neur report also indicated physical therapist (P (OT) for the need/us During the 8/12/13 or 5:15 PM and 7:10 PI #2 did not wear a ga Staff #1 and #2 did r desensitization training	controllably. Staff assisted and, no injury noted. 911 as transported back to the ohysician noted low Depakote previous work (taken at the controllably). Staff assisted and, no injury noted. 911 as transported back to the ohysician noted low Depakote previous work (taken at the controllable). Client from the ER at 5:00 PM on edications, prescription for a ER physician recommended that [client #2] continue to ications as prescribed." If ollow-up report indicated P. The follow-up report "increasing unsteadiness novements are correlated Parkinson's Disease of that lead leads to tremors on the cologist	W 1	89				
	5:22 PM and on 8/13	as reviewed on 8/12/13 at 8/13 at 1:10 PM. Client #2's ords indicated client #2 was						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	· /	ATE SURVEY DMPLETED		
		15G245	B. WING			R		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		08/16/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
W 189	indicated client #2's on to limited to, "Uncoor Parkinson Disease, a without control." The was to follow-up with "roller walker" was of Client #2's Cumulative physician orders indivinclusive): -7/10/13 "Sent to E.F. (treatment) d/t (due to medical condition (urcoordinated moved Type II DM (diabetes & CT head done. Result Appt (appointment) (neurologist) 7-23-13 - 7-19-13 @ 9 AM." -7/11/13 "Gait belt Disease. Pt was recult for proposed for pr	diagnoses included, but were ordinated movements, and Type II diabetes mellitus in ER note indicated client #2 his PCP in 2 days and a dered for client #2. The Medical Records and cated the following (not all cated the following (not all cated the following (change) in insteady gait)." In [name of hospital] DX: ments, Parkinson Disease, mellitus), convulsions. Labs is (prescription) for walker. with) [name of doctor] (a) 10 AM, Appt OT/PT eval (b) (diagnosis): unsteady gait." (c) (diagnosis): unsteady gait." (diagnosed with Parkinson ently seen in the ER at full body tremors per the fith him today. Pt is on sn't have a diagnoses (sic)	W 18	39				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CO 4378 FOURTEENTH LN HOBART, IN 46342	DDE	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 189	Continued From pag	e 48	W	189		
	asleep for client #2. client #2 was to retui The 7/23/13 report ir diagnosis of Seizure	red an EEG awake and The report also indicated In in 6 weeks or as needed. Indicated client #2 was given a Indicated OT evaluation				
	exercise safety around objects. The assess "unable to follow 1 (sic)" The PT ass Home Program: pt is	as a fall risk and should and sharp objects or moving ment indicated client #2 was step commands consistantly essment indicated "Current unable to follow any (home exercise program)				
	provided/Pt inappropriateReco **Requires OT follow appropriate for OT so Recommend 24 hou environment. This p occupational therapy	mmendation/Plan OT Plan Up**: No PT is not ervices at this time. r supervision in structured atient will be seen for skilled				
	Syndrome indicated #2] while ambulating that [client #2] and the dried after showering sure walkways are chazards[Client #2] belt and walker. How	•				
	belt and walker has ([client #2] to reduce	avior plan indicated "A gait (sic) been recommended for these falls. He is extremely ms. A desensitization plan				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA II	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	'	35/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 189	Continued From pag		W 1	89		
{W 210}	also resistant to som desensitization for apadded (sic)." Client indicated the desens and the walker were times a day the grouprogram. Interview with admin #2, and the DHS on client #2 did not wan use a walker. SC #2 desensitization plant belt. SC #2 indicated program staff in regard plan, but he had not in regard to the behalf 9-3-3(a) Within 30 days after interdisciplinary team assessments or reas supplement the prelimination of the sensitization of the prelimination of the sensitization of the sensitization plant in the sen	DUAL PROGRAM PLAN	{W 2 ⁻	0}		
	Based on interview a sampled clients (#2) (#3), the clients' inter reassess client #2's of client's low and/or high	not met as evidenced by: and record review for 1 of 3 and for 1 additional client disciplinary teams failed to diabetic diet in regard to the gh blood sugar levels to see relation, and to reassess s.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	\ , ,	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			R 8/16/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4378 FOURTEENTH LN HOBART, IN 46342		0/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
{W 210}	Continued From pag	e 50	{W 21	0}			
	Findings include:						
		ortable incident reports,					
	Incident/Accident Re	,					
		eviewed on 8/12/13 at 3:23 portable incident reports,					
	1	ations indicated the following:					
	-7/10/13 "This Servic	e Coordinator (SC) (SC #1)					
	received a phone cal	I from the group home at					
	1	AM on 7/10/13 stated that					
		appeared lethargic and his					
		ic). Staff were directed to ose level. It was 210. The					
	_	o transport [client #2] to					
	I .	[name of city], In. Blood					
	1	elded no significant findings.					
		dmitted to the hospital, he					
		the ER (emergency room)					
		/13At 1:00 PM Residential sumer [client #2] from the					
		home after ER discharge.					
		he vehicle (at group home)					
	-	ook uncontrollably. Staff					
		the ground, no injury noted.					
	the ER via ambulanc	2] was transported back to e.					
	1	physician noted low Depakote					
		previous work (taken at er [client #2] was given					
		iters) intravenously while in					
		epakote levels up. [Client					
		rom the ER at 5:00 PM on					
	7/10/13. No new me	dications, prescription for a					
	I .	ER physician recommended					
		-up with his primary care					
	⊢ brivsician (PCP) and	that [client #2] continue to				1	

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			1	₹ 16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	L	-	S 4	STREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN HOBART, IN 46342	1 06/	16/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 210}	-7/11/13 "[Client #2] of sugar) which included combativeness. Heal tech tested [client #2': 369. [Client #2] was contacted Residential with Director of Health closely monitored by changes. [Client #2's and tested at 463. Far and EMT (emergency and checked [client #476. [Client #2] was thospital]." -7/26/13 "Consumer [non-responsive during checked [client #2's] of 40's, and the Nurse wand [client #2] was transpital]." -7/31/13 "[Client #2] was transpital]." -7/31/13. During the part of show signs of hypothis sugar dropped be rushed to [name of helps	cations as prescribed." fame into the workshop at the workshop and it was given water and H&S Tech in Nurse and left message in Services. [Client #2] was staff and H&S Tech for any injected was checked again accility Director called 911 and medical technician) arrived 2's] levels which tested at then transported to [name of the workshop it was in the was notified. 911 was called ansported to [name of was at [name of hospital] in a for a scheduled EEG on procedure [client #2] began and it was in the workshop it was at [name of hospital] in a for a scheduled EEG on procedure [client #2] began and workshop it was one in the workshop it was at [name of hospital] in workshop it was at [name of ho	{W 2	:10}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING				₹
NAME OF P	ROVIDER OR SUPPLIER	100240	3	ST	REET ADDRESS, CITY, STATE, ZIP CODE	08/	16/2013
ARC OF N	IORTHWEST INDIANA IN	C, THE		4378 FOURTEENTH LN HOBART, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{W 210}	hospital. Client #2's record was 5:22 PM and on 8/13/7/10/13 hospital record seen in the ER on 7/1 indicated client #2's donot limited to, "Uncood Parkinson Disease, a without control." Client #2's 7/31/13 Historia indicated client #2 was chief complaint of Hylindicated "patient with diaphoresis (excessive associated with shock emergency conditions EEG done today; pation blood sugar. Hypogly past few days; had 3 An 8/2/13 After Visit Swas discharged back 8/2/13. The summary follow up with his PCI nephrologist in 5 wee weeks. The 8/2/13 stwas placed on a sliding summary indicated "C Novolog Mix 70/30 FI skin 2 (two) times dai apart (sliding scale in seen seen in the ER of the seen seen seen seen seen seen seen se	s reviewed on 8/12/13 at 13 at 1:10 PM. Client #2's rds indicated client #2 was 0/13. The 7/10/13 ER note iagnoses included, but were rdinated movements, and Type II diabetes mellitus story and Physical (H&P) is seen in the ER for the poglycemia. The H&P as reportedly developing the sweating commonly and other medical is and restless while having ent was noted to have low are wists at local ER" Summary indicated client #2 to the group home on a indicated client #2 was to period in 1 week and the law with labs to be done in 4 aummary indicated client #2 and scale. The 8/2/13 other Prescriptions ex pen inject 5 units into the lay before meals" and "insulin sulin coverage) Novolog times daily with meals BS	{W 2	110}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{W 210}	doctor)." The 8/2/13 indicated the facility glucose levels 4 time bedtime (HS). Client #2's Cumulatir physician orders indinclusive): -7/10/13 "Sent to E.f. (treatment) d/t (due medical condition (umedical condition (umedical condition) (units SQ call MD (medical Patient Instructions was to monitor client #2's es daily at meals and at ve Medical Records and icated the following (not all R. for eval (evaluation) & tx to) staff reporting (change) in	{W 21	0}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{W 210}	& call on-call nurse (blood sugar 265- Cothroughout night." -7/23/13 "Spoke w/ (endocrinologist] re: (sugars over 300 and Dr. paged; orders re of endocrinologist] for phone; insulin increa (breakfast) and 20 u (follow-up) for appt resultance (ndition; repeat BS @ 10 PM (with) results. At 10 PM- Intinue to monitor client	{W 2	10}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		15G245	B. WING			08/	16/2013
	ROVIDER OR SUPPLIER	IC, THE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 1378 FOURTEENTH LN HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 210}	crackers & cup of mili- undated note "In case emergency room of the and have [name of ernumber listed] wait for your number with a to two beeps again. The endocrinologist] will result to the professional states of the professional states	give HS snack graham k." e of emergency go to the ne hospital closest to you ndocrinologist] paged [pager or two beeps then place in ouch tone phone. Then wait en hang up. [Name of eturn your call. [Name of s to also be notified about S- Milk or juice." e call from staff @ 5:40 a.m. profusely; c/o (complaints ormed to call 911- adm oucagen. This writer (DHS) ox (approximately) 6:15 BS 42 per EMS; IV dextrose outing to arouse - repeat BS orose (decreased) 30's - oution." 30 ordered 15 units with or with dinner. ont to hospital for EEG origins of hypoglycemia. The outine the swall of the	{W 2	210}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	RIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 08/16/2013
	ROVIDER OR SUPPLIER	IC, THE		STREET ADDRESS, CITY, STATE, ZIP 4378 FOURTEENTH LN HOBART, IN 46342	CODE	GG/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD B THE APPROPRIA	DATE
{W 210}	is 150-199 give 1unit 200-249 give 2units 250-300 give 3units 301-349 give 4 units 350-400 give 5 units. If BS is greater than 4 Nurse/MD" The 8/5/13 change for Medical Record indic obtain clarification in and/or endocrinologis the 7/23/13 order ind order indicated 400. Client #2's August 20 Administration Record facility monitored clied the morning, lunch, Fand at bed time. Clied.	ath meals subq if BS reading at 400 give 6units (sic) and call arm and/or Cumulative ated the facility neglected to regard to when the doctor at wanted to be notified as icated at 300 and the 8/5/13 at 3 Medication at (MARs) indicated the at #2's blood sugar levels in and (evening before dinner) and #2's 8/13 MAR indicated agar levels (not all inclusive): are 342 are 310 are 321 are 435 are 435 are 439	{W 2	10}		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7. 50.25	_		F	₹
		15G245	B. WING			08/	16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA I	NC, THE	1	43	TREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN IOBART, IN 46342	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 210}	Continued From pag	e 57	{W 2	10}			
	was reviewed on 8/1 facility's pager record	ntial Services Pager Review 3/13 at 1:40 PM. The ds indicated the following in s blood sugar levels/readings:					
	and shaking." -7/18/13 352 at 8:07 -7/18/13 353 at 6:12 different glucometer7/22/13 408 at 5:53 -7/24/13 330 at 9:18 -7/27/13 487 at 6:30 feed dinner. Call barafter eating. 10 pm I -7/28/13 398 at 6:20	PM, and then 379 with a PM PM PM "Give p.m. insulin dose ck w/results in 2-21/2 hours BS going down 337." PM "Informed to give p.m. ck) in 2/1/2-3 hrs (hours). PM AM PM documented)					
	Record indicated the doctor/endocrinologi	and/or Cumulative Medical e facility did not inform the st of client #2's high blood 300 prior to 8/5/13 and/or 3.					
	#2 was to carry a sa	yped sheet indicated client ck lunch and a snack to the ocument what was sent and					
	client #2 received an	od journal book indicated i 1800 calorie ADA (diabetic) 013 menus indicated "Hot					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, , ,	PLE CONSTRUCTION G	1, ,	COMPLETED	
		15G245	B. WING			R 08/16/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	<u> </u>	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 210}	8/12/13, 8/15/13, 8/8/23/13, 8/26/13, 8/23/13, 8/26/13, 8/26/13, 8/26/13, 8/23/13, 8/26/13, 8/23/13, 8/26/13, 8/2013 f following menu/food lunch on the following macaroni and chee bread, orange slice -8/9/13 Three ounce noodles, garlic bread carrots, 1 cup mandounce cup of milk8/11/13 Three ounce dirty rice, 1/2 bun, swater8/12/13 2 sliced hoserving of rice, 1 segraham crackers ar Client #2's 6/5/13 A indicated "Client of	cop" on 8/8/13, 8/9/13, 16/13, 8/19/13, 8/19/13, 8/22/13, 129/13 and 8/30/13. cood journal book indicated the ditems sent for the client's ng days: es of chicken, 1/2 cup se, 1/2 cup potatoes, 1 slice of s and water. es of meat, 1/2 cup of 1d, 1/2 cup of peas and darin oranges, water and 8 ces of polish sausage, 1/2 cup salad, fruit cup, yogurt and 16 ounces of water. contains a sessment on Diabetic 1800 calorie meal	{W 21			
	monitor blood suga client #2's 1800 cal regard to the client's to ensure the menu starches, carbohydo which could affect of Client #2's 8/7/13 D "Menus are develop	ing at mealtime. Continue to r." The facility failed to have orie ADA diet re-assessed in shigh/low blood sugar levels s did not contain a lot of rates and/or natural sugars slient #2's blood sugar levels.				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15G245	B. WING			R 08/16/2013		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 4378 FOURTEENTH LN HOBART, IN 46342	CODE	1 00/10/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRIA			
{W 210}	lunch daily. Client #2's 2/28/13 IF interdisciplinary team 7/11/13 and on 7/19/mentioned IDT notes IPP indicated the IDT #2 was discharged freview and/or re-asse ADA diet menus/food client's high/low blood determine if there was Interview with the die by phone, indicated sthe month of May 20 facility had contacted elevated and low bloothe dietician stated "It she was not aware chospitalized until she inservice training. Wo client #2 was diagnost Disease stage 3, the dietician indicated shinsulin changes from The dietician stated she notified in regard in medication, diet chre-evaluate client." The should be made aware adings" which were stated she did not atthe had discussed the clients. The dietician in the client in t	P indicated client #2's (IDT) met on 7/10/13, 13. Client #2's above and/or the client's 2/28/13 I failed to meet since client om the hospital on 8/2/13 to ess client #2's 1800 calorie I journals in regard to the d sugar readings/levels to s any correlation. Itician on 8/13/13 at 1:44 PM, she last assessed client #2 in 13. When asked if the her in regard to the client's od sugar levels and his diet, No." The dietician indicated ient #2 had been came to the facility to do an hen asked if she was aware sed with Chronic Kidney dietician stated "No." The e was not aware of any the 7/31/13 hospitalization. She would "Definitely want to so low blood sugar or change anges to go back and The dietician stated she re of any "abnormal e high or low. The dietician end the IDT meetings but ent's "Plan of Care" in the	{W 2	110}				
		The dietician indicated she ed the client's menus that						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING				⋜ 16/2013
NAME OF P	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	001	10/2010
ARC OF N	IORTHWEST INDIANA IN	IC. THE		4	1378 FOURTEENTH LN		
7.11.0 01 11				ŀ	HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE
{W 210}	Interview with admini- #2, and the DHS on 8 client #2 was hospital blood sugar level read the hospital for an EE client #2 was dischard a sliding scale. The I order for the changes notification. The DHS sugar levels were "up indicated the dieticiar low and high blood su DHS indicated client: lunches July 28, 2013 meals at the worksho indicated they had no ensure all lunches ha approved by the dieti 8/2013 menu was ap client #2 was still eati indicated no one had days the menu called The DHS and DS #1 the menus since the of The DHS, SC #1 and indicated the dietician meetings. SC #1 stat inviting the dietician to The DHS indicated cl was made aware of of sugars. The DHS an had not re-assessed journal/consumption is and/or high blood sug	e dietician indicated the her to re-assess client #2. strative staff #2, SC #1 and 8/14/13 at 1:50 PM indicated lized on 7/31/13 for low ding when the client was at EG. The DHS indicated ged on 8/2/13 and placed on DHS could not locate the softhe insulin and/or doctor stated client #2's blood and down." The DHS in was aware of client #2's ugar level readings. The #2 started carrying sack is versus purchasing hot ps. The DHS and SC #1 indicated the proved by the dietician when ing at the workshop. SC #1 resubmitted menus for the for eating at the workshop. indicated no one reviewed dietician approved them. If administrative staff #2 in had not attended any IDT ted "No one thought of the program (meetings)." itent #2's low and high blood dieticient #2's low and high blood dieticient #2's low and high blood dieticient #2's diet/food in regard to the client's low	{W 2	210}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
			A. BOILD			,	₹
		15G245	B. WING				` 16/2013
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ADC OF A	IODTUWEST INDIANA	INC THE		4:	378 FOURTEENTH LN		
ARC OF N	IORTHWEST INDIANA	INC, THE		Н	IOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
{W 210}	patient he followed. indicated he saw cl The doctor indicate over 400 in his offici indicated when he a #2's morning blood Endocrinologist ind him. The Endocrino orders for client #2' monitored, but the freadings with them The doctor indicate regard to the client' Endocrinologist ind client's PCP was al diabetes. The doct PCP could follow hi "could not handle" to him. When aske #2's hospitalization when client #2 was Endocrinologist ind #2 had been hospit stated "I requested hospitalizations. I r blood sugar levels.' indicated he wanted blood sugar levels whad been changed indicated they shou were over 300. The had written orders to Endocrinologist ind any food journals. "They have not sho	indicated client #2 was a The Endocrinologist ient #2 at his office on 8/15/13. It client #2's blood sugar level ie. The Endocrinologist asked the nurse what client sugar reading was, the icated the nurse could not tell blogist stated he had written is blood sugar levels to be facility did not bring all the except the "PM readings." If he made some changes in is insulin on 8/15/13. The icated the nurse told him the iso seeing the client for his ior stated he told them the is diabetes and if his PCP in they could bring the client back if if he was aware of client if the Endocrinologist asked hospitalized and why. The icated he was not aware client alized. The Endocrinologist	{W 2	110}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 08/16/2013	
	ROVIDER OR SUPPLIER	IC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342			00/10/2010	
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{W 210}	indicated she took cli 8/15/13 and the client 8/15/13. LPN #2 indi food journal but the d 2. A review of client at the facility's admini 2:30 P.M Review of a "Nutritional Assessr indicated: "Weight: 1 Weight: 169-186Di Review of client #3's indicated the following Medical notation date of colon wall thickenir Weight loss continued down additional 8 1/2 recommend colonosc note came up medical assess increase calon Medical notation date [Physician name] spot for nutritional supplemented weekly." Medical notation date entryAppointment to visit with [Physician name] with the recommendations for testing further evaluar Medical notation date entryAppointment to visit with [Physician name] called this writtent anything about his weekly.	ist on 8/15/13. LPN #2 ent #2's menu for today t's lunch on hand for cated she had client #2's octor did not look at it. #3's record was conducted strative office on 8/13/13 at f client #3's record indicated ment" dated 6/5/13 which 59 lbs (pounds)Ideal Body et Order: Regular Diet." "Cumulative Medical" record g: d 7/25/13: "Multiple areas ng, possible mass or colitis. s now at 152.5 pounds, pounds. Strongly popy/lower GI testingOf id ineligible todayAlso ries." d 7/31/13: "Called ke to [Nurse name] orders mentto have weights d 7/31/13: "Late o be scheduled for follow-up ame] re: weight loss colonoscopy/lower GI tions." d 8/2/13: "[Client #3 Aunt erstated nobody is doing	{W 2	10}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		15G245	B. WING			08/	16/2013
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 210}	the past three months 100% of all meals and Weekly weights will complete the following (not all in the following (not all	petween 157-159 pounds for s. Consumer consume densure supplement. ontinue." 2013 Weight Chart indicated inclusive): 29 pounds 19 pounds 88 pounds 83 pounds 83 pounds 86 pounds 67 pounds 69 pounds 67 pounds 67 pounds 68 pounds 69 pounds 67 pounds 69 pounds 60 pounds	{W 2	:10}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	15G245	B. WING	ST	REET ADDRESS, CITY, STATE, ZIP CODE	08/	16/2013
	IORTHWEST INDIANA IN	C, THE		43	78 FOURTEENTH LN OBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 210}	every Monday, and the review the tracking she risk plan indicated clie once a week at the daindicated the Health & the weights and send The 5/2013 risk plan in 3lbs (pounds) in a we Nurse will evaluate the client's doctor. The riwould keep a record of consumption. A review of the Direct weights spread sheet conducted on 8/14/13 the spreadsheet indice monthly. The spread #3 was weighed week An interview with the (DON) was conducted administrative office of When asked how offer the DON stated "Mon was documentation to weighed weekly, the lat the day program are send the information on my spring her documented sprewas weighed weekly, When asked if client had been addressed loss noted on 7/25/13 sure." When asked if	the facility's nurse would be the facility's nurse would be the facility's mould be weighed any program. The risk plant is Safety Tech would monitor them into the nurse weekly. Indicated "If plus or minus the facility is set the Community Services the findings" and contact the sk plan indicated the nurse of client #3's food Or of Nursing services client no date noted was at 1:30 P.M Review of atted client #3 was weighed sheet did not indicate client dly. Director of Nursing services that the facility's in 8/14/13 at 2:30 P.M on client #3 was weighed, thly." When asked if there is indicate client #3 was DON stated "He is weighed in when they weigh him they so me and I put the read sheet." When asked if ad sheet indicated client #3 she stated "No, monthly." #3's weight loss risk plan since his 8.5 pound weight, the DON stated "I'm not the doctor or nutritionist fiter the noted weight loss,	{W 2	:10}			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 08/16/2013		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG					
{W 210}	,	ited on 7/3/13. The facility systemic plan of correction	{W 2	10}				
{W 318}	483.460 HEALTH CA The facility must ensuservices requirements	ure that specific health care	{W 3	18}				
	Based on observation review, the facility fail Participation: Health (sampled clients (#2) at (#3). The facility's Health Care Services and/or address a client regard to diabetes. The Services failed to ensure its needs of the clients it Health Care Services and/or address a client regard to diabetes. The Services failed to ensure contacted in regard to blood sugar levels, and regard to when to confacility's Health Care risk plan was revised #2. The facility's Health Care risk plan was revised #2. The facility's Health Care risk plan was revised #3's weight and/or assessed. Findings include:	failed to assess, monitor not's health care needs in the facility's Health Care ure a client's doctor was the client's elevated/high not to obtain clarification in stact the physician. The Services failed to ensure a and/or developed for client alth Care Services failed to ght loss was monitored						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING				≺ 16/2013
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{W 318}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 66 regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed. The facility's Health Care Services failed to monitor client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The facility's Health Care Services failed to ensure the facility's nursing services met the client's health needs in regard to assessing the client timely upon discharge from the hospital and to ensure nursing services carried out physician's orders as written. The facility's Health Care Services failed to ensure the client's physician was notified of a hospitalization and/or notified the physician of high blood sugar level readings. The facility's Health Care Services failed to ensure the dietician was informed/involved in the interdisciplinary team process to assist the facility to review/address the client's elevated sugar levels in regard to the client's diet, and to develop a risk plan for a medical condition. The facility's Health care Services failed to re-assess client #3's weight loss, obtain weekly ordered weights and/or monitor the client #3 in regard to the client's weight loss. Please see W331. This deficiency was cited on 7/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence.		{W 3	18}			
{W 331}	483.460(c) NURSING	ride clients with nursing	{W 3	31}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	. ,	COMPLETED		
		15G245	B. WING _			R 08/16/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	ı	00/10/2013	
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{W 331}	Based on observatireview for 1 of 2 san additional client (#3) services failed to me diabetic client and a amount of weight. Findings include: 1. The facility's repolated for a client /Accident Reinvestigations were investigations were investigations were investigations were investigations. -7/10/13 "This Service received a phone cate approximately 8:30 of consumer [client #2] gait was unsteady (seek his blood gluonurse directed staff in [name of hospital] in tests and CT scan y [Client #2] was not a was discharged from at 12:30 PM on 7/10 prescriptions for a weight proposed for the consumer [client #2] group home after Endisembarking the verwing the proposed for the group home after Endisembarking the verwing for the group home after Endisembarking the verwing for the group for the gro	on, interview and record inpled clients (#2) and for 1, the facility's nursing set the nursing needs of a client who had lost significant ortable incident reports, sports (IAR) and/or reviewed on 8/12/13 at 3:23 ortable incident reports, IARs indicated the following: See Coordinator (SC) (SC #1) If from the group home at AM on 7/10/13 stated that appeared lethargic and his sic). Staff were directed to sose level. It was 210. The to transport [client #2] to [name of city], In. Blood is leded no significant findings. Indicated to the hospital, he in the ER (emergency room) in the ER	{W 33				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
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{W 331}	Continued From pag	e 68	E W}	31}			
	(seizure) levels from initial visit). Consum Zalerate 100ml (millil the ER to bring his de #2] was discharged f 7/10/13. No new me walker written. The Ethat [client #2] follow physician (PCP) and take his current medi The facility's 7/19/13 client #2 saw his PCI indicated client #2's and uncoordinated m with his diagnosis of (disorder of the brain and difficulty walking follow-up with a neur report also indicated physical therapist (PCOT) for the need/use -7/11/13 "[Client #2] 9:00 AM with signs of sugar) which include combativeness. Heatech tested [client #2] 369. [Client #2] was contacted Residentia with Director of Healt closely monitored by changes. [Client #2's and tested at 463. Fand EMT (emergency and checked [client #2's and che	that lead leads to tremors). It is recommended he ologist" The follow-up client #2 would see a T) and occupational therapist e of adaptive equipment. came into the workshop at f hyperglycemia (high blood					

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			F 08/	₹ 16/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN			4	STREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN HOBART, IN 46342	007	10/2013
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{W 331}	client #2 followed up or (diabetes specialist) or changed the client's in a changed the client #2's or checked [client #2's] or checked [client #2's] or checked [client #2] was transported to a change of city], Indiana 7/31/13. During the properties to show signs of hyporous or compared to the	follow-up report indicated with his Endocrinologist on 7/15/13 and the doctor insulin dosage. Iclient #2] was g a routine bed check. Staff glucose and it was in the vas notified. 911 was called ensported to [name of or a scheduled EEG on procedure [client #2] began polycemia (low blood sugar). Flow 30. [Client #2] was pospital] emergency room. Iclient #2] was pospital] emergency room. Iclient #2 staff when they called his ated the client was taken to determined his blood sugar and he was admitted to the	{W 3	31}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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{W 331}	center (facility owner Novolog insulin, ensitest strips were avail on the MAR (medicand trained the head orders. The Directoup with [client #2's] The facility's 8/9/13 "3. What measure prevent this from had done with the nurse review of all discharall orders are carried. The facility's 8/5/13 nurse involved in the Market of the facility's training 8/12/13 at 4:00 PM. Individual Client Tra DHS completed train discharge, reviewing orders and following medication changes the group homes. Interview with admir at 4:15 PM indicated group home nurses indicated the DHS of worked with the Foundaministrative staff were not the only nu LPN #1 was a "temp LPN #2 was a full tin nursing services fail	d day program) to provide sured that the glucometer and lable, transcribed the orders ation administration record), th and safety tech on the new or of Health Services will follow primary care physician." follow-up report indicated es are being implemented to ppening again? Training was swhich consisted of thorough ge hospital orders and ensure dout." IAR indicated LPN #1 was the electror. g records were reviewed on The facility's 8/5/13 ining Forms indicated the	{W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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{W 331}	Continued From page	ge 71	{W 33	31}			
	5:15 PM and 7:10 F #2 did not wear a gs Staff #1 and #2 did desensitization train Client #2's record w 5:22 PM and on 8/1 7/10/13 hospital recommendated client #2's not limited to, "Uncommendated client #2's vithout control." The was to follow-up wite "roller walker" was of #2's 7/10/13 lab rep glucose level was 2 Valproic Acid level w second 7/10/13 ER diagnosis included, Convulsions." The client #2's seizures Seizures." The attata Instructions indicated (NES) is a short per how you move, thin epileptic seizure, bu changes in the brain Early diagnosis and prevent further prob Client #2's 7/31/13 indicated client #2 v chief complaint of H indicated "patient	ras reviewed on 8/12/13 at 3/13 at 1:10 PM. Client #2's cords indicated client #2 was 7/10/13. The 7/10/13 ER note diagnoses included, but were coordinated movements, and Type II diabetes mellitus are ER note indicated client #2 th his PCP in 2 days and a cordered for client #2. Client cort indicated client #2's 80 at the ER and the client *2's note indicated client #2's but was not limited to, second 7/10/13 note indicated were "Non-Epileptic ched 7/10/13 Discharge at "Non-epileptic seizure ciod of symptoms that change k, or feel. NES looks like an at there are no electrical in. NES is a serious condition.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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{W 331}	emergency conditions EEG done today; pati blood sugar. Hypogly past few days; had 3 The 7/31/13 H&P indi insufficiency, most lik effectWill consult [r nephrology" An 8/2/13 After Visit S was discharged back 8/2/13. The summary follow up with his PCI nephrologist in 5 wee weeks. The 8/2/13 si was placed on a slidii summary indicated "C Novolog Mix 70/30 Fl skin 2 (two) times dai apart (sliding scale in Flex Pen inject three (blood sugar) 150-19 (subcutaneous) 200-249-2U SQ 250-300-3U SQ 301-349-4U SQ 350-400-5U SQ > (more than) 400-6 todoctor)." The 8/2/13 indicated the facility viglucose levels 4 times bedtime (HS). The 8 indicated a doctor at medication changes, endocrinologist. Client #2's 8/6/13 Neclient #2's diagnosis in the sugar and sugar sugar and sugar	s) and restless while having ent was noted to have low acemia has been recurrent ER visits at local ER" cated client #2 had "renal ely from medication name of doctor] Summary indicated client #2 to the group home on a indicated client #2 was to in 1 week and the ks with labs to be done in 4 ammary indicated client #2 ing scale. The 8/2/13 Other Prescriptions ex pen inject 5 units into the lay before meals" and "insulin sulin coverage) Novolog times daily with meals BS in 1 units SQ call MD (medical Patient Instructions was to monitor client #2's a daily at meals and at 1/2/13 After Visit Summary	{W 3	31}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING				R 16/2013
	ROVIDER OR SUPPLIER	IC, THE	•	43	TREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN IOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	physician orders indicinclusive): -7/10/13 "Sent to E.R (treatment) d/t (due to medical condition (un -7/10/13 "Eval @ (at) uncoordinated mover Type II DM (diabetes & CT head done. Rx Appt (appointment) (v (neurologist) 7-23-13 - 7-19-13 @ 9 AM." -7/11/13 "Gait belt DX -7/15/13 (8:25 AM) "E Status update given to office- Client taken to rec'd (received) to (in 20 units and p.m. dos office in 4 weeks- app 10:30 AM." -7/22/13 "Rec'd phon @ 7:15 pm- reports co (subcutaneous) giver breathing/snoring louinformed to call 911 in Dextrose as per staff client aroused- no EF informed to give dinnethis time; monitor con & call on-call nurse (v	kidney function). The Medical Records and cated the following (not all all all all all all all all all al	{W 3	331}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	C, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		
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{W 331}	the request of the DO The Arc. Pt has been Disease. Pt was rece [name of hospital] for social worker here will Depakote but he does of seizures." The 7/2 Carbidopa-Levodopa milligrams daily with refacility was to start then 1 with breakfast with each meal. The the Neurologist order asleep for client #2. In client #2 was to return The 7/23/13 "Spoke w/ (wendocrinologist] re: (resugars over 300 and Dr. paged; orders recof endocrinologist] for phone; insulin increas (breakfast) and 20 un (follow-up) for appt new 1-7/23/13 Faxed note in call [name of endocrinologist] re: [number listed]. 2. In units before breakfast Please make sure par insulin." On the botto sheet, the facility's number listed.	ro pt (patient) sent here at N (Director of Nursing) at a diagnosed with Parkinson ently seen in the ER at full body tremors per the th him today. Pt is on son't have a diagnoses (sic) 3/13 note indicated (Parkinson Disease) 25-100 meals. The note indicated t with breakfast for 1 week, and lunch for 1 week, then 1 neurology report indicated ed an EEG awake and The report also indicated in 6 weeks or as needed. dicated client #2 was given a	{W 3	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15G245	B. WING			08/16/2013		
	ROVIDER OR SUPPLIER	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	1 007.10120.10			
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{W 331}	25 before breakfast -7/23/13 (5:30 PM) writer) (Director of H 45 informed to hold of bread & serving of home for outing. St during outing (with) of hypo/hyperglycer to home." -7/23/13 (8:20 PM) outing. B.S. 53 whe (subcutaneous) glue supper @ outing are repeat BS in 1 hourup to 98 informed to crackers & cup of m -undated note "In caemergency room of and have [name of number listed] wait your number with a two beeps again. Tendocrinologist] will Endocrinologist] will Endocrinologist] will Endocrinologist] wall B/S over 300Low -7/26/13 "Rec'd phose 47- client sweating of) stiff muscles - in (administer) sub Q garrived @ home appa.m EMS present given- [client #2] corprofusely/EMS atter	and 20 units at supper. "While visiting home (this lealth Services)- client's BS p.m. insulin- 1 cup milk, slice of rice given prior to leaving aff informed to obtain BS any s/s (signs and symptoms) in a & repeat BS when return "Client (without) incident @ en returned home- sub Q cagen given per staff; ate bound 7-7:15 pm- informed to call w/results. 9:25 PM BS in give HS snack graham ilk." ase of emergency go to the the hospital closest to you be endocrinologist] paged [pager for two beeps then place in touch tone phone. Then waith then hang up. [Name of return your call. [Name of return your call. [Name of the stoles of	{W 33	1}				

1 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	` '	COMPLETED R		
		15G245	B. WING			08/16/2013		
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		00/10/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
{W 331}	Continued From pag	ge 76	{W 33	1}				
	-7/26/13 Novolog 70 breakfast and 10 un	/30 ordered 15 units with its with dinner.						
	testing and showed note indicated client and admitted with a note indicated client ultrasound and bloo	ent to hospital for EEG signs of hypoglycemia. The #2 was transported to the ER blood sugar below 30. The #2 was to have a kidney d work completed. lient post hosp (hospital)						
	return. Client alert e responsive. 0 (zero (respirations) even & lung sounds clear, b W/D intact. V/S (vita received et noted. 0 [name of PCP] in 1 v 5 wks." The facility's assess client #2 upo							
	-8/12/13 Client #2 s follow-up to the 7/31	aw his family doctor for a /13 hospitalization.						
	indicated client #2 w exercise safety arou objects. The assess "unable to follow 1 (sic)" The PT ass Home Program: pt is exercises. No HEP provided/Pt inappropriateReco	PT and OT evaluation as a fall risk and should and sharp objects or moving ament indicated client #2 was step commands consistantly assessment indicated "Current a unable to follow any (home exercise program) mmendation/Plan OT Plan a Up**: No PT is not ervices at this time.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONST	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING				R
	ROVIDER OR SUPPLIER	L	STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342			1 00/	16/2013
(X4) ID PREFIX TAG			ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	environment. This particle occupational therapy independence with m Client #2's 8/5/13 Me indicated client #2 ha order/change. The 8/Novolog 70/30 5 units breakfast and dinner Novolog 3xs a day wit is 150-199 give 1unit 200-249 give 2units 250-300 give 3units 301-349 give 4 units 350-400 give 5 units If BS is greater than 4/Nurse/MD" The 8/5/13 change fo Medical Record indical Record indicated 100. Client #2's August 200.	supervision in structured stient will be seen for skilled for optimal return to eaningful occupations" dication Change Form d a new medication (5/13 form indicated "Give s 2xs (times) a day before subq. Give Insulin apart th meals subq if BS reading 400 give 6units (sic) and call rm and/or Cumulative ated the facility neglected to regard to when the doctor st wanted to be notified as cated at 300 and the 8/5/13	{W 3	31}	DELIGITION 1)		
	the morning, lunch, P and at bed time. Clie	nt #2's blood sugar levels in M (evening before dinner) nt #2's 8/13 MAR indicated agar levels (not all inclusive):					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
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		15G245	B. WING _		08	3/16/2013	
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{W 331}	was reviewed on 8/1: facility's pager record regards to client #2's -7/8/13 302 at 5:55 P and shaking." -7/18/13 352 at 8:07 -7/18/13 353 at 6:12 different glucometer. -7/22/13 408 at 5:53 -7/24/13 330 at 9:18 -7/27/13 487 at 6:30 feed dinner. Call back after eating. 10 pm E -7/28/13 398 at 6:20 insulin dinner re(check Call w/results." -8/2/13 328 at 10:31 -8/3/13 444 at 1:39 P -8/4/13 341 (no time -8/5/13 304 at 6:50 A Client #2's pager log Record indicated the call/inform the doctor	er 342 er 310 er 321 her 435 1 her 439 2. htial Services Pager Review 3/13 at 1:40 PM. The ds indicated the following in blood sugar levels/readings: PM, client #2 was "unsteady AM PM, and then 379 with a PM	{W 33	51}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING			8/16/2013		
	ROVIDER OR SUPPLIER	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	, ,			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
{W 331}	Continued From page 8/5/13 and/or over 4		{W 33	1}				
	#2 was to carry a sa	typed sheet indicated client ack lunch and a snack to the document what was sent and						
	client #2 received a diet. Client #2's 8/2 lunch Eat at worksh	ood journal book indicated n 1800 calorie ADA (diabetic) 013 menus indicated "Hot op" on 8/8/13, 8/9/13, 16/13, 8/19/13, 8/22/13, 29/13 and 8/30/13.						
		ood journal book indicated the I items sent for the client's ng days:						
		es of chicken, 1/2 cup se, 1/2 cup potatoes, 1 slice of s and water.						
	noodles, garlic brea	es of meat, 1/2 cup of d, 1/2 cup of peas and larin oranges, water and 8						
		ces of polish sausage, 1/2 cup alad, fruit cup, yogurt and						
	serving of rice, 1 se	ot dogs, 1 slice of bread, 1 rving of salad, fruit cup, d 16 ounces of water.						
	facility's nursing ser dietician review, dev	orie ADA diet indicated the vices failed to to have the velop and/or approve the ack lunch menus for client #2.						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	_	COMP	LETED
		15G245	B. WING _			F	≺ 16/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, S 4378 FOURTEENTH LN HOBART, IN 46342	STATE, ZIP CODE	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRI	C'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	Client #2's 8/13 menurating services failed menu was developed menu for the upcomit 8/19/13, 8/22/13, 8/2 8/30/13. Client #2's 6/5/13 An indicated "Client or plan as ordered by M carbohydrate countin monitor blood sugar. services failed to ensand approved all lung group home staff. The failed to have client # re-assessed in regard blood sugar levels to contain a lot of starch natural sugars which sugar levels. Client #2's 8/7/13 Dia "Menus are developed for review for approvinsk plan indicated cli lunch daily. The 8/7/"During sleep check in bed as he may be sweat through his cloblood sugar. If blood sugar. If blood sugar. If blood sugar. If blood sugar.	u indicated the facility's ed to ensure an approved d for client #2's sack lunch ng days of 8/15/13, 8/16/13, 3/13, 8/26/13, 8/29/13 and nual Nutritional Assessment n Diabetic 1800 calorie meal	{W 3	31}	DETICIENCE!)		
	-Dry Mouth -Increased thirst -Headache -Nausea and Vomitin	g					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		15G245	B. WING			08/	16/2013
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ADC OF N	ORTHWEST INDIANA IN	C THE			4378 FOURTEENTH LN		
ARC OF N	OKTHWEST INDIANA IN	C, THE			HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	100units/ml injection of sliding scale MD order sugar is above 400 60 flexpen should be adriscale MD orders and notify MDlf 911 is cashould be completed. plan failed to specificate facility staff were to more regard to the client's sublood sugar levels to condition could be impreceded by the condition c	e 150 Novolog flexpen will be administered per rs, (sic) If [client #2's] blood units (sic) of Novolog ministered Sub-Q per sliding Call the nurse/nurse to alled an Incident report" Client #2's 8/7/13 risk ally indicate how often conitor client #2 at night in signs/symptoms of low/high ensure any change of mediately addressed. A plan for Parkinson's Staff will to monitor [client (sic)Staff will make sure the bathroom floor are fully bathingStaff will make ear of obstacles and tripping the part of obstacles and tripping the part of bett and the stion plan has been this plan" Client #2's the gait (sic) belt and the stion plan has been this plan" Client #2's the gait belt, and/or ty staff were to keep the slient's gait was unsteady. Mor 2/28/13 Individual indicated the facility's nursing tress/develop a risk plan for	{W 3	331			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 08/16/2013	
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	IC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	 	00/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{W 331}	belt and walker has (a [client #2] to reduce to resistant to these iter for this is being added also resistant to some desensitization for appended (sic). Client #2 indicated the desensition and the walker were stimes a day at the group program.	vior plan indicated "A gait sic) been recommended for hese falls. He is extremely his. A desensitization plan d to his plan. [Client #2] is emedical appointment pointment is also be in 2's 7/13 behavior plan tization plans for the gait belt to be run/implemented 5 bup home and at the day	{W 3	31}			
	interdisciplinary team 7/11/13 and on 7/19/mentioned IDT notes IPP indicated the IDT #2 was discharged for review and/or make reclient's risk plans. Clarecord indicated the frontacted the dieticia gave input and/or was meetings. Client #2's the facility's nursing sand/or ensure the client eclient #2's 1800 compournals in regard to the sugar readings/levels any correlation. Interview with staff #1 at 6:41 PM when ask transported to the hostated client #2 would hospital when the client was reading with the client #2 would hospital when the client #2 would have the client #2 would	(IDT) met on 7/10/13, 13. Client #2's above and/or the client's 2/28/13 failed to meet since client om the hospital on 8/2/13 to needed changes to the ient #2's 2/28/13 IPP and/or acility's nursing services n to ensure the dietician					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100240		STREET	ADDRESS, CITY, STATE, ZIP CODE	08	/16/2013	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
{W 331}	Continued From page	e 83	{W 3	31}				
	client #2 was monitor blood sugar/symptom	ularities." When asked how red at night in regard to his as, staff #1 stated "I check I work." Staff #2 indicated nights.						
	by phone, indicated so the month of May 20 facility had contacted elevated and low blood the dietician stated "No she was not aware classification of the dietician stated and low blood the dietician stated and low bigging and the dietician indicated she inservice training. Work client #2 was diagnost Disease stage 3, the dietician indicated she insulin changes from The dietician stated so the notified in regard to in medication, diet chard re-evaluate client." To should be made award readings which were stated she did not attained discussed the clipast. The dietician in communicated with the to the client's menus. The dietician in communicated with the tothe client's menus. The facility had not asked Interview with administant properties of the dietician in the client with the dietician in communicated with the tothe client's menus. The facility had not asked Interview with administant properties with administant properties.	came to the facility to do an hen asked if she was aware sed with Chronic Kidney dietician stated "No." The e was not aware of any the 7/31/13 hospitalization. The would "Definitely want to to low blood sugar or change anges to go back and the dietician stated she are of any "abnormal high or low. The dietician end the IDT meetings but ent's "Plan of Care" in the idicated she had not the Endocrinologist in regard. The dietician indicated she ed the client's menus that the dietician indicated the her to re-assess client #2. Strative staff #2, SC #1 and 3/14/13 at 1:50 PM indicated lized on 7/31/13 for low						
	client #2 was hospita blood sugar level rea							

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING		R 08/16/2013		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		10/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
{W 331}	a sliding scale. The order for the change notification. The DH sugar levels were "u indicated the dieticia low and high blood s DHS indicated client lunches July 28, 201 meals at the workshindicated they had nensure all lunches happroved by the diet 8/2013 menu was approved by the diet and indicated no one had days the menu called The DHS and DS #1 the menus since the The DHS, SC #1 and indicated the dietician sC #1 and #2 indicated additional IDTs since she was not aware of Chronic Kidney Dise indicated diabetes of function. SC #1 and did not have a risk p SC #1 and #2 indicated client #2 had indicated client #2 had indicated client #2 had using his walker and had trained the day indesensitization plan, group home staff in the DHS indicated cient #2 had the DHS indicated cient #4 had	rged on 8/2/13 and placed on DHS could not locate the s of the insulin and/or doctor S stated client #2's blood p and down." The DHS n was aware of client #2's augar level readings. The #2 started carrying sack 3 versus purchasing hot ops. The DHS and SC #1 ot reviewed the menus to ad been reviewed and/or ician. SC #1 indicated the oproved by the dietician when ting at the workshop. SC #1 indicated menus for the d for eating at the workshop. indicated no one reviewed dietician approved them. In administrative staff #2 in had not attended any IDT ated "No one thought of to the program (meetings)." Ited there had been no a 7/19/13. The DHS indicated dient #2 had a diagnosis of ase stage 3. The DHS indicated client #2 lan for his new diagnosis. Ited client #2 did not want to do do a walker. SC #2 and a desensitization plan for gait belt. SC #2 indicated he orogram staff in regard to the but he had not trained the regard to the behavior plan.	{W 33				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 08/16/2013	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		33710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{W 331}	indicated client #2 w for a walker but a gaplace. When asked client #2 safe as the gait belt, SC #1, the #2 indicated the IDT in place. The DHS in Endocrinologist was low and high blood sthe doctor would not pages/calls. The DH the doctor on 7/23/11 his office, the pager DHS indicated the doctorified if client #2's 300. The DHS indicated the doctorification to 400. The DHS indicated the	uation by the OT and PT ould not be a good candidate it belt had been put into how the facility was keeping client did not want to utilize a DHS and administrative staff would need to put something indicated client #2's made aware of client #2's made aware of client #2's made aware of client #2's sugars. The DHS indicated always return his als indicated she spoke with and/or his cell phone. The octor still wanted to be blood sugar levels were over ated she was not aware the lers had changed the The DHS indicated the d have sought clarification of e clients' doctors of blood on or 400. When asked if the ed the doctor of client #2's sugar levels, the DHS stated is there was no octor was called: DM AM PM, and then 379 with a PM PM PM PM PM PM PM PM PM	{W 3:	31}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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15G245		15G245	B. WING			08/	16/2013	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				4	STREET ADDRESS, CITY, STATE, ZIP CODE 1378 FOURTEENTH LN HOBART, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{W 331}	called in regard to bloch The DHS, SC #1 and IPP did not specificall were to monitor the clisigns and symptoms sugars. The DHS and had not re-assessed journal/consumption if and/or high blood sugard. Interview with the End 1:45 PM, by phone, in patient he followed. Indicated he saw clien The doctor indicated over 400 in his office, indicated when he as #2's morning blood sugard. Endocrinologist indicated with the fact in the doctor indicated in the fact in t	er 342 er 310 er 321 her 435 leer 439 2. e doctor should have been hod sugar levels over 300. SC #2 indicated client #2's y indicate how facility staff lient at night in regard to of high and/or low blood d SC #1 indicated the IDT client #2's diet/food in regard to the client's low par levels. docrinologist on 8/15/13 at indicated client #2 was a The Endocrinologist int #2 at his office on 8/15/13. client #2's blood sugar level The Endocrinologist ked the nurse what client	{W 3	331}				

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			R	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	1 0	8/16/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{W 331}	PCP could follow his "could not handle" the to him. When asked #2's hospitalization, the when client #2 was hendocrinologist indic #2 had been hospital stated "I requested to hospitalizations. I result indicated he wanted blood sugar levels." indicated he wanted blood sugar levels we had been changed to indicated they should were over 300. The had written orders to Endocrinologist indic any food journals. To "They have not show The Endocrinologist indic any food journals. To "They have not show The Endocrinologist in the facility was not me sugar levels as order Interview with LPN #2 and #2 on 8/15/13 at saw the endocrinologist indicated was 432 at the doctogiven 15 units of Novoffice. When asked we to the appointment, a indicated LPN #2 was ugar levels as they indicated she took the	diabetes and if his PCP ey could bring the client back if he was aware of client he Endocrinologist asked ospitalized and why. The ated he was not aware client ized. The Endocrinologist be notified of quested to be notified of The Endocrinologist to be called when client #2's ere over 300. When told it 400, the Endocrinologist I call him when the levels Endocrinologist indicated he indicate such. The ated he was not aware of the Endocrinologist stated in me any food journals." Indicated he was concerned onitoring client #2's blood ed. 2 and administrative staff #1 2:30 PM indicated client #2	{W 33	11}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	15G245 B. WING		R 08/16/2013				
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				43	TREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN OBART, IN 46342	1 00/	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	for the doctor to reviet took client #2's menur client's lunch on hand indicated she had clied doctor did not look at endocrinologist had be client's hospitalization indicated the doctor whospitalization. LPN was told to call the enadmission. LPN #2 incall him. LPN #2 stat "removed" the sliding on 25 units Novolog a supper. LPN #2 indicassess clients within the hospital. Administ previous nurse did not client #2. Administration was dor investigation was dor investigation was to be When came to me I to investigated as negle. Interview with administ 10:50 AM indicated the medication/order home when clients' madministrative staff #24 hours to assess a the group home per to the hospital/physician staff #1 indicated the #2's blood sugar at the supplemental programment in the programment in the hospital physician staff #1 indicated the #2's blood sugar at the supplemental programment in the programm	, PM and bed time readings w. LPN #2 indicated she for today 8/15/13 and the for 8/15/13. LPN #2 ent #2's food journal but the it. When asked if the feen made aware of the fin, administrative staff #1 was told of the made and placed client #2 indicated the hospital indicated the hospital did not find client #2's doctor scale and placed client #2 at breakfast and 20 units at find the waste of discharge from strative staff #1 indicated the find a timely assessment of the strative staff #2 stated "An fine to determine if an fine done. They said not hold them this should be ct." strative staff #1 on 8/16/13 and nursing staff would send change form to the group finedications were changed. I indicated nursing staff had client once discharged from	{W 3	31}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			\ , ,	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 08/16/2013	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP 4378 FOURTEENTH LN HOBART, IN 46342	•	00/10/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{W 331}	8/5 and 8/6/13. Adm the group home staff as the orders sent ho different from what the the hospitalization. At the on-call nurse "was the orders on the MA stated LPN #1 indica was not going to the Administrative staff # longer employed with 2. A review of client at the facility's admin 2:30 P.M Review of a "Nutritional Assess indicated: "Weight: 169-186D Review of client #3's indicated the followin Medical notation date of colon wall thickeni Weight loss continue down additional 8 1/2 recommend colonos note came up medical assess increase calconditional supplementation of the colon wall thickeni weight loss continued assess increase calconditional supplementation date [Physician name] specifor nutritional supplementation date entryAppointment to visit with [Physician name] specific mutritional supplementation date entryAppointment to visit with [Physician name]	sinistrative staff #1 indicated had called the on-call nurse one with the client were he client had received prior to administrative staff #1 stated alked them through writing kR." Administrative staff #1 sted on 8/2/13, "She (LPN #1) group home at 4:00 PM." at indicated LPN #1 was no in the facility. #3's record was conducted distrative office on 8/13/13 at a staff client #3's record indicated ment" dated 6/5/13 which 159 lbs (pounds)Ideal Body ite Order: Regular Diet." "Cumulative Medical" record ag: #2 of 7/25/13: "Multiple areas and, possible mass or colitis. It is now at 152.5 pounds, 2 pounds. Strongly copy/lower GI testingOf add ineligible todayAlso bries." #2 of 7/31/13: "Called obke to [Nurse name] orders mentto have weights #2 of 7/31/13: "Late to be scheduled for follow-up name] re: weight loss or colonoscopy/lower GI	{W 3	31}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING		R
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	08/16/2013
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{W 331}	Continued From page	90	{W 33	1}	
		d 8/2/13: "[Client #3 Aunt erstated nobody is doing eight loss"			
	maintained a weight the past three months 100% of all meals and Weekly weights will co	ontinue."			
	Client #3's 2012 and a the following (not all in	2013 Weight Chart indicated nclusive):			
	-June 2012 2 -July 2012 18 -August 2012 18 -September 2012 17 -October 2012 17 -December 2012 17 -January 2013 17 -February 2013 17 -April 2013 15 -May 2013 18 -June 2013 1	19 pounds 19 pounds 38 pounds 33 pounds 33 pounds 66 pounds 67 pounds 67 pounds 67 pounds 67 pounds 68 pounds 69 pounds			
	plan indicated "[Clie weight loss. [Client # diet. [Client #3] is not Baseline: [Client #3's ideal body weight sho The risk plan indicate [client #3] to eat all his	Weight Management risk ont #3] had a history of 3] was on a portion control on a regular diet.] current weight is 169. His uld be between 165-205." d "Staff is to encourage is food and encourage him to are to monitor [client #3's]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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{W 331}	food intake by size are food intake on tracking the Community Servi intake is less than 1/4 meal." The risk plan were to be submitted every Monday, and the review the tracking shrisk plan indicated cli once a week at the dindicated the Health of the weights and send The 5/2013 risk plan 3lbs (pounds) in a we Nurse will evaluate the client's doctor. The rewould keep a record consumption. A review of the Direct weights spread sheet conducted on 8/14/13 the spreadsheet indice monthly. The spread #3 was weighed week week week at the day program a send the information on my spher documented spreads weighed weekly, the at the day program a send the information information on my spher documented spreads weekly.	and report and document his alg sheet. Staff should call ces Nurse if [client #3's] food at of the entire meal at every indicated the tracking sheets to the Service Coordinator ne facility's nurse would meets at least monthly. The ent #3 would be weighed any program. The risk plan as Safety Tech would monitor them into the nurse weekly. Indicated "If plus or minus sek the Community Services are findings" and contact the lisk plan indicated the nurse of client #3's food stor of Nursing services client to date noted was at 1:30 P.M Review of cated client #3 was weighed sheet did not indicate client kly. Director of Nursing services dat the facility's con 8/14/13 at 2:30 P.M en client #3 was weighed, withly." When asked if there to indicate client #3 was DON stated "He is weighed and when they weigh him they	{W 3	31}		

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{W 331}	had been addressed loss noted on 7/25/13 sure." When asked if had been contacted a the DON stated "I'm r	since his 8.5 pound weight s, the DON stated "I'm not the doctor or nutritionist after the noted weight loss, not sure." ited on 7/3/13. The facility systemic plan of correction	{W 3	31}			